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FORCE HEALTH PROTECTION CONCEPT OF OPERATIONS (CONOPS)

17 November 2011



**Office of the Assistant Secretary of Defense (Health Affairs)
Office of Strategy Management,
Force Health Protection and Readiness, and
Joint Staff/J4 Health Services Support Division**

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EXECUTIVE SUMMARY

For the last several years, the Military Health System (MHS) has pursued organizational transformation in concert with the Department of Defense (DoD). The Joint Force Health Protection (JFHP) Concept of Operations (CONOPS) was developed in July 2007, in response to the Deputy Secretary of Defense (DepSecDef) Memorandum on Improving Joint Warfighting through JFHP Transformation, and incorporated transformation planning of the Services focusing on the operational level of JFHP. Subsequently in March 2010, the overarching Health Readiness (HR) CONOPS was developed and validated, reorganizing the CONOPS structure of the MHS with three supporting CONOPS: Health Service Delivery (HSD), Health System Support (HSS), and Force Health Protection (FHP) (revision of the JFHP CONOPS).

The FHP CONOPS, like its predecessor the original JFHP CONOPS, describes how DoD medical capabilities are organized and synchronized to support the MHS mission. The FHP CONOPS supports the health capability framework established in the HR CONOPS and serves to specify how the MHS enables mission success by serving the health care needs of deployed forces. It builds upon the JFHP CONOPS and incorporates the overarching vision and organizational structure of MHS HR CONOPS family of documents to include strategic guidance from the Task Force on the Future of Military Health Care.

The FHP CONOPS creates an executable vision for significantly improving MHS interoperability and mission effectiveness. The FHP CONOPS will support rigorous follow-on assessment and analysis of force health protection-related capabilities through Capabilities Based Assessments (CBA). These CBAs will analyze new and existing requirements; determine capability gaps, shortfalls and overmatches with appropriate Doctrine, Organization, Training, Materiel, Leadership and Education, Personnel, and Facilities (DOTMLPF) analysis, and recommend appropriate materiel and non-materiel solutions for presentation and adjudication as part of the broader DoD Joint Capabilities Integration and Development System (JCIDS) effort. The FHP CONOPS is a key component, in conjunction with the HSS and HSD CONOPS, that supports the overarching HR CONOPS in guiding combatant commanders and medical communities in the development and employment of Health Readiness solutions.

Chapter 1 presents the strategic construct of the FHP CONOPS as providing a framework to -

- Identify a set of force health protection related capabilities
- Inform efforts to improve integrated FHP capabilities within the context of the four mission elements and related mission outcomes described in the HSS CONOPS, HSD CONOPS, and the MHS Strategic Plan

Chapter 2 presents emerging challenges and from these challenges presents a problem statement. The joint force needs to solve the basic military medical challenge of how to more effectively ensure FHP for a Joint Force that will operate in a complex and diverse operational environment and collaborate with other organizations, agencies, nations, and cultures.

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Chapter 3 introduces the twelve FHP functional areas, which support the four MHS mission elements:

- Casualty Care and Humanitarian Assistance
- Healthy, Fit and Protected Force
- Healthy and Resilient Individuals, Families, and Communities
- Education, Research, and Performance Improvement

Chapter 4 describes the twelve FHP capabilities: Human Performance Optimization (HPO); Provide a Healthy and Fit Force (Health and Wellness); Provide Public Health/Veterinary Services; Non-clinical Preventive Medicine/Health Surveillance; Global Patient Movement; Casualty Management; Medical Command and Control, Shared Situational Understanding and Awareness; Support to Stability Operations (Security, Stability, Transition, and Reconstruction Operations); Support to Homeland Defense and Civil Support Operations; Detainee Medical Care; and Operational Medical Logistic Management and Integration Support.

Chapter 5 presents the strategy for implementing this CONOPS. Effective FHP concept implementation establishes a basis to enter new and existing FHP capabilities into the formal JCIDS process. Effective application of the FHP transformation strategy will enable prioritization of transformation investments among capabilities that address future risks and balance against the other risk areas identified in the 2010 Quadrennial Defense Review (QDR) and future reviews.

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1.0 CHAPTER 1 STRATEGIC CONSTRUCT

Today, military forces are conducting a wide range of civil-military operations and activities, including security and policing assistance, humanitarian relief, reconstruction, governance, civil capacity building, medical and security cooperation. Hardly new to the Department, military forces have performed these missions for more than a century and likely will continue to do so in the future. However, recent operations have exposed gaps between civilian and military capabilities, and highlighted a need to develop a better understanding of how civilian-military efforts must be mutually supportive and when operations should transition between military-led and civilian-led activities.¹

The Health Readiness (HR) CONOPS defined Force Health Protection (FHP) as the ability to sustain and protect the health and effectiveness of the human centerpiece of the American Military. FHP is composed of activities that promote Human Performance Optimization (HPO); provide for a healthy, fit, and protected force; engage in health surveillance and shared situation awareness across all medical partners; encompass an integrated casualty management in the Joint Operations Area (JOA); and enhance mission set preparedness and support to Stability Operations and Homeland Defense/Civil Support (HD/CS) .

1.1 PURPOSE

The purpose of the FHP CONOPS is to support the rigorous assessment and analysis of health-related capability gaps and inefficiencies through a Capabilities-Based Assessment (CBA) process. This assessment will identify materiel and non-materiel solutions within the DoD through the Joint Capabilities Integration and Development System (JCIDS).

This CONOPS provides the analytic framework to identify FHP- related capabilities and inform efforts to improve integration within the context of the four mission elements and related outcomes described in the HR, Health Systems Support (HSS) and Health Service Delivery (HSD) CONOPS and the Military Health System (MHS) Strategic Plan. The CONOPS gives direction to joint and service operational medicine and health care programs, influences science and technology efforts, and will help guide combatant commanders and medical community development and employment of FHP solutions.

1.2 SCOPE

Health Readiness operations are increasingly delivered as joint operations and in conjunction with interagency entities, multinational partners, intergovernmental organizations (IGO), and non-governmental organizations (NGO). As a result, this CONOPS broadly describes future joint medical force operation across a range of military operations in the context of the Capstone Concept for Joint Operations (January 2009). The CONOPS also includes associated medical capability requirements, risks and implications as applied to worldwide operations.

¹ Quadrennial Roles and Missions Review Report, January 2009, p. 34.

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The FHP CONOPS envisions military operations conducted in accordance with the National Defense Strategy (NDS) and further focuses on describing FHP capabilities for Joint Force Commanders and applies to geographic and functional Combatant Commanders (COCOMs), military services, defense agencies, and joint staff for concept development and experimentation. The FHP CONOPS integrates elements of the HSS and HSD CONOPS, the four MHS mission elements and related outcomes from the MHS Strategic Plan which drive the overall HR strategy; acknowledges service-unique medical missions and capabilities relative to the HSS, HSD, and this FHP CONOPS; considers MHS dimensions across the range of military operations and the key elements of Joint Integrating Concepts outlined in the Manual for Joint Concept Development and Experimentation (CCJCM 3010.02C) and the Manual for the Operation of the Joint Capabilities Integration and Development System (JCIDS).

1.3 CONTEXT

For too long, the health of the All-Volunteer Force, the civilian workforce that supports it and the processes by which the Department provides needed equipment and platforms have been underemphasized priorities. The prolonged wartime period since 2001 has greatly elevated their importance, and the consequences of failure have accordingly become more serious. To reflect the urgency that the Department's leadership places on these issues, the QDR has striven to include them as core components of our policy, planning, and programming considerations.²

The Assistant Secretary of Defense for Health Affairs (ASD(HA)) serves as the program manager for all DoD health and medical resources and will exercise authority, direction, and control over the DoD medical and dental personnel authorizations and policy, facilities, programs, funding, and other resources in the DoD.³

The HR CONOPS separates health readiness capabilities between the FHP (formerly the JFHP CONOPS), HSS and HSD CONOPS.

Chapter 3 describes the mission elements, corresponding FHP capabilities and their overlapping nature. The four mission elements are interdependent and are briefly described as follows:

- Casualty Care and Humanitarian Assistance – An integrated and responsive research methodology and education and training system must develop a capacity that is essential to achieving improvements in operational care and evacuation. Force Health Protection capabilities that support this mission element include but are not limited to: Provide Public Health/Veterinary Services; Non-Clinical Preventive Medicine/Health Surveillance; Global Patient Movement; Casualty Management; Shared Situational Understanding and Awareness, including severe environmental conditions; and Operational Medical Logistics Support.
- Fit, Healthy, and Protected Force – The most critical aspect of the system is to produce the quality of medical professionals and assemblages needed for an anytime, anywhere

² Quadrennial Defense Review Report, p.16. February 2010.

³ Department of Defense Directive (DoDD) 5136.01, 4 June 2008.

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mission. Force Health Protection capabilities that support this mission element include but are not limited to: Human Performance Optimization Capabilities; Provide a Healthy and Fit Force (Health and Wellness); Preventive Medicine/Health Surveillance; Provide Public Health/Veterinary Services; Shared Situational Understanding and Awareness; and Operational Medical Logistic Support.

- **Healthy and Resilient Individuals, Families and Communities** – Sustaining the quality of these medical professionals cannot occur without a uniformed base and beneficiary platform that produces healthy individuals, families, and communities. Force Health Protection capabilities that support this mission element include but are not limited to: Provide Public Health/Veterinary Services; Preventive Medicine/Health Surveillance; Global Patient Movement; Casualty Management; Support to Homeland Defense and Civil Support Operations; and Operational Medical Logistic Support.

- **Education, Research, and Performance Improvement** – Sustaining mission success relies on the MHS' ability to adapt and grow in the face of a rapidly changing health and national security environment. To accomplish this effort, the MHS must be a learning organization that values personal and professional growth and supports innovation. Force Health Protection capabilities that support this mission element include but are not limited to: HPO Capabilities; Provide Public Health/Veterinary Services; Shared Situational Understanding and Awareness; and Operational Medical Logistic Support.

1.4 ASSUMPTIONS

The FHP CONOPS revision is based on the following assumptions:

- Success across the range of military operations depends on support of a single MHS mission with four independent but integrated, mission elements
- The MHS will follow strategies to support medical transformation as described in the Quadrennial Defense Review (QDRs)
- Recommendations outlined in the Action Memorandum for the DepSecDef titled: "Joint/Unified Medical Command Way Ahead" dated 27 November 2006 (listed below) remain relevant:
 - Take incremental and achievable steps that will yield efficiencies of operations
 - Achieve true economies of scale by combining common functions
 - Provide structural changes enabling MHS QDR Transformation initiatives
 - Preserve service-unique culture and mission support capabilities for each of the services' medical components
 - Support the principles of unity of command and effort under joint operations
 - Maintain Under Secretary of Defense Personnel & Readiness (USD(P&R)) and ASD(HA) oversight of the Defense Health Program

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- Facilitate consolidation of medical headquarters under 2007 Base Realignment and Closure (BRAC) law
- Create a joint environment for the development of future MHS leaders
- Position the MHS for further advances, and if warranted, toward more unification while ensuring that unique service medical capabilities are maintained

The *2008 MHS Strategic Plan* and subsequent updates will remain the roadmap for integrating HR

- Net-centric operations environment and Battlespace Awareness (BA) will enable a fully networked and collaborative medical communications system, including telemedicine and intelligence environment.
- Information assurance (IA) will be achieved and maintained
- Evolution of joint military culture and training will keep pace with advancements in technology
- The United States will continue to have global interests and responsibilities that will require continued engagement across the globe, necessitating greater cultural awareness and language capability across the joint force
- Advances in technologies will significantly enhance integrated health surveillance, risk assessment, and countermeasures. Health surveillance should include all co-located personnel, allow interface with coalition partner systems and/or, at a minimum, allow external data to be fed into the Joint systems.
- DoD investments in global communications capabilities will provide for the architecture and infrastructure required for successful implementation of FHP

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2.0 CHAPTER 2 MILITARY FORCE HEALTH PROTECTION CHALLENGE

It is evident that years of war have imposed considerable strain on the All-Volunteer Force. Multiple long deployments are taking a significant toll on our people. Given the requirements of Afghanistan, Iraq, and other operations, the Department remains deeply committed to constantly assessing the health of the force. We will do all we can to ensure that our people are as prepared as possible for their wartime service while working to lessen the burden shouldered by our personnel and their families—the most important pillar of America’s defense.⁴

United States Forces will face challenges “ranging from regular and irregular wars in remote lands, to relief and reconstruction in crisis zones to sustained engagement in the global commons. During this time, the causes of conflict will vary from rational political calculation to uncontrolled passion.”⁵

2.1 MATURE AND EMERGING CHALLENGES

The traditional battlefield has transformed into a diverse and unpredictable environment with disparate threats and methods such as chemical, biological, radiological, and nuclear weapons posed by adversaries who have strong motivation to adopt asymmetric methods to counter US advantage. In addition to traditional capability models, a new array of challenges has emerged:

- **Traditional challenges**—are posed by the states employing recognized military capabilities and forces in well-understood forms of military competition and conflict.
- **Irregular challenges**—come from those employing “unconventional” methods to counter traditional advantages of stronger opponents.
- **Catastrophic challenges**—involve acquisition, possession, and use of weapons of mass destruction (WMD) or methods producing WMD-like effects.
- **Disruptive challenges**—may come from adversaries who develop and use breakthrough technologies to negate current US advantages in key operational domains.⁶

2.2 FUTURE KEY ASPECTS OF THE FORCE HEALTH PROTECTION ENVIRONMENT

The following key aspects of the future security environment will influence the development of concepts and capabilities critical to the success of future health operations:

- **Increased emphasis and concern for survivability and longevity of care for wounded warriors.** While wounded warriors are surviving and recovering from

⁴ Quadrennial Defense Review Report, p.3. February 2010.

⁵ Joint Operational Environment, page 3

⁶ National Defense Strategy of the United States of America, p. 2, 2005

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battlefield injuries due to advances in battlefield medicine, resuscitative and rehabilitative care, challenges related to the long-term health implications of survivability and reintegration continue to evolve.

- **A more complex and diverse operational environment that spans the global community and includes land, ocean, atmosphere, space, and cyberspace.** Future conflicts will appear as hybrids comprising diverse, dynamic, and simultaneous combinations of organizations, technologies, and techniques that defy categorization.⁷ New capabilities must support Whole-of-Government and Global Health Engagement approaches to mitigate conflicts beyond the conventional nation state domains within all environments and in accordance with Chemical, Biological, Radiological, Nuclear, and High Yield Explosive (CBRNE) Survivability policy.
- **Healthcare operations require a combination of capabilities to maximize complementary and additive effects.** Joint medical operations must match service capability sets to optimize operations in certain situations and physical domains.
- **Technology proliferation.** Information technology, high-resolution imagery, telemedicine, and the electronic health record (EHR) will provide an ability to deploy leaner, more capable medical solutions requiring development of innovative and adaptable skill sets among a diminishing healthcare workforce.
- **Increased emphasis on containing DoD health costs.** Multiple forces contribute to the unrelenting cost pressures driving tactical and transformational changes in how health services are delivered worldwide.

2.3 FUTURE JOINT FORCE OPERATIONS IMPACTING FORCE HEALTH PROTECTION

*Lessons from ongoing conflicts and assessments of the likely security environment point to a challenging operational landscape for America's Armed Forces. Perhaps more than ever before, the United States requires joint military forces able to function and succeed across a wide geographic and operational spectrum. Moreover, military forces must be capable of working effectively with a range of civilian and international partners.*⁸

Understanding the characteristics of the future force, including medical, is key to FHP transformation. The Capstone Concept for Joint Operations heads the family of joint operations concepts (JOpsC) that describes how joint forces are expected to operate across the range of military operations through 2016 and beyond. It builds on the National Defense Strategy description of the four emerging challenges and the need to adapt to a dynamic environment. In addition to operating in multiple domains, the integrating joint forces (including multinational and nonmilitary agencies) must be complementary, reinforcing, and interdependent. Prerequisites of interdependence are interoperable systems, understanding of differing capabilities, and integration of effects for unified action.

⁷ *Capstone Concept for Joint Operations* (CCJO), p. 8, January 2009

⁸ Quadrennial Defense Review, p. 7, February 2010

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Net-centric operations can accelerate the ability to know, decide, and act by linking sensors, communications systems, and weapons systems in an inter-connected grid. Utilizing a secure network will increase sharing of information, provide actionable information at all levels of command, and create conditions for greater collaboration and coordination in real time, resulting in faster decision-making, greater self-synchronization, and greater precision of desired effects.

Small changes in the initial conditions can result in enormous changes in outcome. Thus, speed will be a defining characteristic of the future joint force; the ability to decide and act faster than our opponent allows us to define or alter the initial conditions on terms favorable to our interests. The goal is to develop a dynamic situation and, in particular, one that is changing at a higher rate of speed than that with which an adversary can keep pace, while at the same time sharply narrowing the adversary's strategic options. The necessary speed is not of the response but within it: speed of deployment, speed of organization, speed of employment, and speed of sustainment.

New approaches for projecting power will place a premium on enhancing US active and passive defenses against missiles and CBRNE weapons; distributing forces throughout a theater of operations and developing new net-centric concepts of operations; reducing the dependence of US forces on major air and sea ports for insertion; increasing US reliance on stealth, standoff, hypersonic, long-range, and unmanned systems for power projection; enhancing capabilities to project and sustain power directly from an integrated sea base; continuing to improve capabilities for littoral engagements; and developing ground forces that are more agile, more lethal, more versatile, more survivable, more sustainable, and rapidly deployable. These new approaches require equally new approaches to sustain US forces in anti-access environments and to attain the DoD goal of reducing its logistics footprint.

The joint force will undertake a range of future operations in an environment that will present significant challenges to FHP. Major combat operations may entail large numbers of friendly, enemy, and civilian casualties who must be treated. Irregular warfare will likely require broadly dispersed units with associated requirements for distributed medical care and long-range evacuation. Stability operations will require restoration and enhancement of indigenous medical capabilities as well providing care to a significant civilian population in distress. Building partnerships will require an enhanced medical training capability. Civil support and disaster relief operations will require support to, and integration with, civilian medical capabilities within our nation and abroad. Shaping operations to undermine the causes of instability and prevent crises will require increased use of FHP assets to assist local populations.

2.4 FORCE HEALTH PROTECTION ELEMENTS OF THE PROBLEM

The emerging way of war provides the context for FHP transformation. The following are key HR elements of this military problem that FHP must address:

- Lack of a fully integrated military health system that includes not only interoperability between the services, but also through all the levels of war (tactical, operational, and strategic). The speed of planning and execution of

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future joint forces will not allow for industrial age medical organizations, processes, and information sharing systems; therefore, future medical forces must be net-centric and interoperable to be a fully integrated military health system with the ability to make decisions and implement them in real time.

- Medical capabilities that are sufficiently flexible, scalable, modular, and agile enough to meet future requirements. Medical expeditionary capabilities must be able to rapidly integrate new advancements in medical sciences. The future medical force must be more agile, more capable, more versatile, more survivable, more sustainable, and rapidly deployable.
- The speed, simultaneity, and dispersed nature of future joint operations challenge current medical employment concepts for forward resuscitative care, theater hospitalization, and patient movement (PM). The future medical force will leverage emerging medical technologies, new lift platforms, and new employment methods to provide forward resuscitative care to dispersed units within the times required to save life, limb, eyesight, and provide sustained or progressively increasing en-route care to definitive treatment.
- Current medical information systems do not fully facilitate data sharing, net-centric operations or “sense and respond” capabilities.
- Insufficient opportunities for joint medical training and shortage of medical personnel to conduct training, and simultaneously meet mission requirements. The future medical force will require joint training that matches the speed and intensity of the emerging way of war using joint medical doctrine that enables interdependent and mutually supporting medical operations.
- The need for joint medical logistics and infrastructure support (JMLIS) capabilities to better anticipate and respond to the specialized materiel requirements of more modular, capable, and agile medical forces operating in complex and uncertain environments. A fully integrated military health system must have the ability to continuously sense and assess medical threats and adapt to rapid changes in the operating environment, force composition, and/or changes in materiel demands to ensure the right materiel and equipment are available to the right person at the right place and time for uninterrupted support to force health protection.
- The need to better leverage materiel and non-materiel solutions that enhance human performance.
- The need for a fully integrated Patient Movement (PM) system that provides visibility on all patients within the system from point of injury to final disposition.
- Current health systems and processes lack comprehensive capabilities along the entire continuum of care and include aspects of care across a full range of military operations.

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- Current medical systems, equipment, and forces lack capabilities to operate in all types of environments, including multinational operations, security, transition, and reconstruction operations; operations with NGOs and IGOs; medical capacity building; and public health services.
- The joint force will be increasingly dispersed in smaller elements, operating in a distributed manner over an increasingly large area of operations. Providing support to these dispersed small units will create a significant challenge for the MHS.

2.5 FORCE HEALTH PROTECTION PROBLEM STATEMENT

The problem that faces the joint force is to determine how to more effectively provide health protection to a force that will operate in a complex and diverse operational environment; confront a range of traditional and new adversaries and threats; employ and integrate new technologies; and collaborate with other organizations, agencies, nations and cultures. The mission is broad and powerful; “our team provides optimal Health Services in support of our nation’s military mission—anytime, anywhere.”⁹

⁹ Military Health System Strategic Plan, p. 2, 2008

3.0 CHAPTER 3 FORCE HEALTH PROTECTION CONCEPT

This CONOPS focuses on the optimal provision of twelve FHP capabilities in conjunction with the four MHS mission elements to achieve mission outcomes through integration with HSS and HSD capabilities. This concept describes the capabilities required for enhancing FHP, as supported and sustained by HSS and HSD capabilities, relative to the life cycle management of these integrated MHS capabilities.

3.1 SYNOPSIS OF THE CENTRAL IDEA: PROTECT THE FORCE, ENHANCE THE MISSION

FHP is an ability to sustain, improve, protect, and conserve the health and resilience of Service members for optimal mission performance across global military activities and operations. FHP comprises activities that promote HPO; provide for a healthy, fit, protected and resilient force; engage in health surveillance; communicate at the FHP level; execute a seamless integrated medical system through shared situation awareness; sustain clinical requirements through proactive and dynamic medical logistics operations; encompass casualty care management; patient management from any Joint Operations Area; and enhance mission set preparedness and support to Stability Operations (SO) and HD/CS.

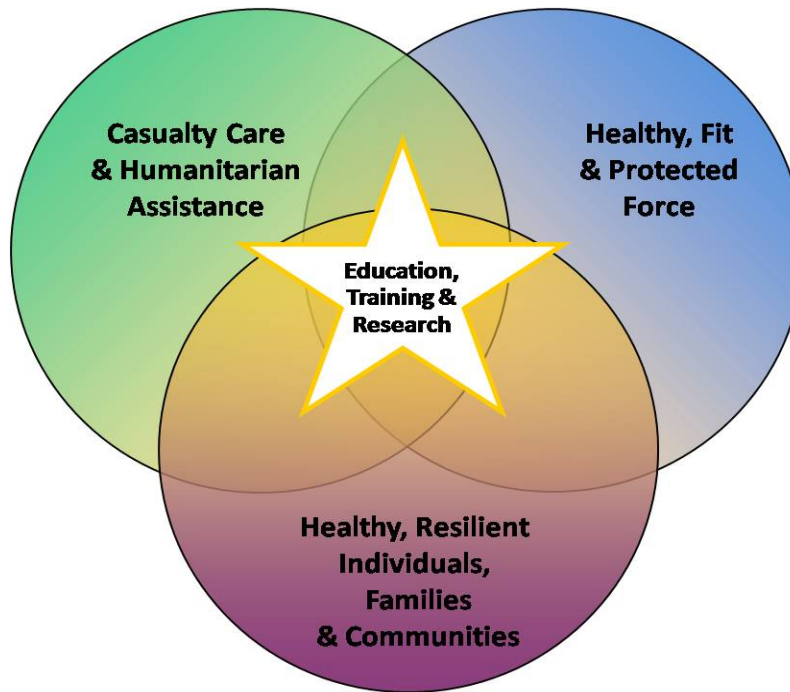
3.2 FOUR MISSION ELEMENTS

Force Health Protection encompasses a broad spectrum of operational medical capabilities required to promote, protect, improve, conserve, and restore the mental and physical well-being of service members. Joint Publication (JP) 4-02 defines FHP as “measures to promote, improve, or conserve the mental and physical well-being of Service members. These measures enable a healthy and fit force, prevent injury and illness, and protect the force from health hazards” and represent a significant change from past medical concepts. Military healthcare is being reshaped into more responsive, joint-centered capabilities, with greater balance between prevention and treatment.

The capabilities described in this FHP CONOPS represent a mixture of all tasks, defined in JP 4-02 as force health protection.

The capabilities essential to implementing the FHP strategy described in Chapter 4 were developed as defined by the HR CONOPS within the context of the four MHS mission elements (Figure 3-1) and mission outcomes outlined in the *2008 MHS Strategic Plan*, shown and described below:

Figure 3-1: Four Mission Elements



3.2.1 Mission Element 1: Casualty Care and Humanitarian Assistance

The MHS generates, maintains, and deploys an agile, highly capable medical force that provides an interoperable healthcare delivery system that enables state-of-the-art health services anytime, anywhere. It uses this medical capability to treat casualties, restore function, support humanitarian assistance and disaster relief, and build bridges to peace worldwide. The desired mission outcomes resulting from efforts to promote Casualty Care and Humanitarian Assistance are:

- Reduce combat losses (consequences of wounds).
- Provide effective medical transition from service and seamless transition from battlefield to Department of Veterans Affairs (VA) or other rehabilitation.
- Improve rehabilitation and reintegration.
- Increase Interoperability with allies, Other Government Agencies, IGOs and NGOs.
- Reconstitute Host Nation (HN) medical capability.
- Support the combatant commander's theater security cooperation initiatives.

HSD and HSS are reliant on the FHP capabilities that are critical enablers, in support of providing Casualty Care and Humanitarian Assistance.

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3.2.2 Mission Element 2: Fit, Healthy, and Protected Force

The MHS will help Service commanders create and sustain the most healthy and medically prepared fighting force anywhere. The desired mission outcomes to promote Fit, Healthy, and Protected Force are:

- Reduce medical non-combat loss.
- Improve mission readiness.
- Optimize human performance.

Enhancing current, and identifying strong, joint FHP capabilities for the future will ensure that the Joint Force Commander has a fit, healthy and protected force. For example, medical information management must be synchronized with a myriad of medical systems to track combat and non-combat loss injuries, track components of individual medical readiness and human performance. Integrated medical logistics and business systems (contracting, financial) must be agile and responsive to materiel demands of FHP as well as maintain medical materiel readiness for force protection (FP).

3.2.3 Mission Element 3: Healthy and Resilient Individuals, Families, and Communities

The MHS provides long-term health coaching and care for all DoD beneficiaries. Our goal is a sustained partnership that promotes health and creates a resilience to recover quickly from illness, injury, or disease. The desired mission outcomes to promote Healthy and Resilient Individuals, Families, and Communities are:

- Healthy communities/healthy behaviors (public health).
- Healthcare quality.
- Access to care.
- Beneficiary satisfaction and perception of MHS quality.
- Perception of MHS quality by recruitment pool.

Maintaining healthy and resilient individuals is a necessity and obligation the MHS can only accomplish with the help of TRICARE contractors, community organizations, and educational institutions. The consistent achievement of quality healthcare delivery and sustainment of a satisfied, world-class health care team requires enabling FHP capabilities that respond rapidly and precisely to the unique needs of the MHS.

3.2.4 Mission Element 4: Education, Research, and Performance Improvement

Sustaining mission success relies on the MHS' ability to adapt and grow in the face of a rapidly changing health and national security environment. To accomplish this effort, the MHS must be a learning organization that values personal and professional growth and supports innovation. The desired mission outcomes to promote Education, Research, and Performance Improvement are:

- Capable medical workforce.

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- Advancement of medical science.
- Advancement of global public health.
- Create and sustain the healing environment (facilities).
- Performance-based management and efficient operations.
- Performance-based focus for joint medical education and training.

Effective support to health education, research and performance improvement requires health expertise and a complete understanding of the challenges and priorities associated with providing global military health support.

3.3 ENHANCED INTEROPERABILITY AND INTERDEPENDENCE WITHIN THE MILITARY HEALTH SYSTEM

To transform the medical force into a fully integrated health system across the range of military operations, the future medical force must support Service unique missions and operate with an optimal degree of interoperability and interdependence. The future medical force can be light, versatile and act with great speed while collectively maintaining all the capabilities required to support the force. In the past, the MHS capabilities largely represented the sum of independently developed service programs without maximizing opportunities for enhanced interoperability and interdependency through joint development and standardization. Current military strategies mandate the medical force structure be more responsive in diverse operations including stability and capacity building operations integrating with civilian public health sectors and providing health care support to host nation personnel, DoD civilians and contractors, and other civilians in need.

3.4 SUPPORTED CAPABILITY AREAS

The two additional functional capability areas comprising HR are described below.

3.4.1 Health Service Delivery

Health Service Delivery describes institutional HR capabilities required to deliver comprehensive health care in military treatment facilities and via a network of health industry and interagency partners in support of the MHS mission. Health Service Delivery provides an ability to build healthy communities by managing and delivering the TRICARE health benefit, using medical treatment facilities (MTF) along with TRICARE network of healthcare providers and partnership development among health service organizations outside the DoD. Health Service Delivery includes health quality and safety, clinical preventive medicine, clinical diagnostics, treatment, rehabilitation, and reintegration for those entrusted to our care.

3.4.2 Health Systems Support

Health Systems Support describes the organization and execution of capabilities to sustain, and continuously improve, MHS mission effectiveness through focused development of people, technology, and infrastructure. Health Systems Support includes health services contract development, health services contract management, and

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partnership development among health service organizations outside the DoD; managing the total medical force; health education and training; medical financial management; medical/health information management; creating and sustaining the healing environment; medical logistics and medical research and development.

Health Service Delivery and Health System Support are further defined in the supporting HSD and HSS CONOPS as prescribed by the HR CONOPS and are subject to existing and future department policy.

3.5 FORCE HEALTH PROTECTION CAPABILITY AREA OPERATIONAL VIEW

Health Readiness must integrate and optimize all capabilities into an agile system of systems supported and enabled by FHP, HSD, and HSS as its foundation. Force Health Protection relies upon all four mission elements of HR with a focus on the how they support the needs of deployed Commanders and their Expeditionary Forces.

Force Health Protection is a fully integrated health system which interacts with deployed beneficiaries primarily across the first three mission elements (1) casualty care and humanitarian assistance; (2) fit, healthy and protected force; and (3) healthy and resilient individuals. However, FHP, HSS and HSD depend heavily on the innovations and quality of capabilities derived from the fourth element: education, research, and performance improvement.

4.0 CHAPTER 4 FORCE HEALTH PROTECTION CAPABILITIES

Chapter 4 describes the twelve FHP capabilities required for operating in the manner described in the central and supporting ideas of Chapter 3. These capabilities and tasks are further refined with Conditions/Attributes and Standards in Appendix A. Force Health Protection capabilities are interdependent with HSS and HSD capabilities and enable the seamless delivery of health care and improve health outcomes.

4.1 FORCE HEALTH PROTECTION CAPABILITIES

4.1.1 Human Performance Optimization (HPO) Capabilities

HPO will improve the ability of the future joint force to complete essential tasks. HPO will extend physical and mental endurance and enhance physiological and psychological resilience to reduce injury and illness. It examines factors that stress the deployed force, and improves Warfighter success on the battlefield and between deployments. Effects should include enhanced physical resilience, physiological resilience, psychological resilience, reduced recovery time from injury, and reduced rates of injury and illnesses.

Manage Warfighter Fatigue. The ability to evaluate and monitor fatigue, predict and manage effects on Warfighter performance, and develop methods for countering the effects of fatigue.

Optimize Human Systems Integration (HSI). The ability to support integration of the Warfighter (human system) into all systems across the entirety of the system's life cycle (development, design, production, fielding and sustainment) and to sustain or enhance human performance reduces Warfighter morbidity and mortality and improves mission performance.

This capability is based on the understanding that humans are critical elements within systems, and adopting a human-centric perspective of systems increases total system performance and minimizes total ownership costs. It provides for the most efficient use of limited human resources by comprehensively integrating them within larger joint and Service socio-technical systems. Such a perspective necessarily spans all joint capability areas (JCA), joint functional areas, and joint operating concepts. Human systems integration goes well beyond consideration of human-machine interface design and involves deliberate planning to efficiently leverage all domains of human systems integration: human factors engineering; personnel; training; manpower; environment, safety and occupational health; habitability; and survivability. Optimizing HSI could include designing interfaces that allow for decreased training requirements or accommodation of a variety of user skill levels. While HSI is portrayed within the CONOPS as a sub-set of the parent HPO capability, it is, in fact, an overarching discipline impacting the entirety of the FHP landscape. When HSI is consistently and comprehensively applied it will favorably inform/influence not only its parent capability, but also the other eleven capability areas that are central to supporting and sustaining the four inter-related MHS mission areas.

Enhance Warfighter Sensory, Cognitive, and Motor Capabilities. The ability to enhance and sustain sensory capabilities; manage/control sensory inputs; enhance and

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sustain cognitive performance; and monitor, assess, and use the physical and mental status of individual Warfighters and units to enhance commanders' decision-making.

This capability focuses on physiological/metabolic and neurocognitive processes underlying sensory, cognitive and motor capabilities. It involves enhancing, controlling, or sustaining sensory capabilities. Sustainment aims at maintaining baseline sensory capability in other-than-optimal operational environments involving, for example, laser threats, anti-vision weapons, or conditions resulting in short and long term hearing loss. Enhancements include, but are not limited to, recognition of sensory stimuli beyond unaided levels (i.e., vision and hearing abilities enhanced beyond enemy capabilities but without loss of normal aspects such as visual field, acuity, and depth perception). Improved capabilities are especially needed under austere conditions such as fog, smoke, low light, or excessive sensory inputs (e.g., glare, explosions, engine noise, etc.).

Cognitive capability enhancement includes augmenting perception, comprehension, mental model formulation, and future projection to maximize performance and decision-making. Failure can lead to task saturation, information overload/inadequacy, stress, and errors.

Motor capability enhancement can include sustaining baseline physical capability for extended durations in other-than-optimal operational environments (e.g., when degraded from injury, illness or incapacitation as a result of operational exposures); increasing abilities above baseline levels for speed, endurance, strength, and faster than normal physical conditioning; and providing commanders the ability to assess/utilize/incorporate the real time physical and mental status of s DoD expeditionary personnel in their decision-making processes.

Enhance Warfighter Learning, Communications and Decision-making. The ability to enhance individual and team learning/training with high retention of knowledge/skills, individual and team communication, situational awareness (SA), and decision-making.

This capability focuses on the physiological/metabolic/neurocognitive processes underlying learning, communications and decision-making. A key goal of enhanced individual Warfighter and team learning/training is high retention of knowledge/skills with minimal decay. The desired outcomes of this capability can include increasing training cycle efficiency and maintaining subject detail without mission failures due to lack of an individual's information retention.

The goal of enhancing communication is to convey information rapidly and effectively, eliminating failures and inefficiencies. Enhancements may differ for one-to-one, one-to-few and one-to-many, collocated and distributed communication scenarios, as well as for various situational interactions (e.g. joint or multi-national; controlling/supervising subordinates vs. a mob of angry citizens). The approach to enhancing communications must consider both traditional and novel communication modalities.

The capability to enhance decision-making includes providing readily available information in a format that is quick and easy to process and understand. The influences

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on autonomous decision-making skills (often thought to be developed through experience or observation) are poorly understood. Automated decision-making and augmented cognition will enable improved, and more-timely, decisions.

Enhance Physiological Capability. The ability to improve DoD expeditionary personnel success within the physiological domain to decrease brain injury (neuroprotection), manipulate metabolic processes (related to water intake, nutrition, and waste production), and enhance the ability to withstand trauma and maintain enhanced performance.

The focus of this area is to maintain, optimize, or enhance the physiological capabilities of the Warfighter despite the physical, social, and mental stressors of military operations. This may include sustaining normal physiological capabilities or enabling super-physiological capabilities beyond unaided human capabilities. It may include manipulation of metabolic processes such as those related to water or nutrition intake, or temporarily intervening to eliminate or delay bodily waste production.

Other areas involve enhancing the ability to withstand trauma. It includes the ability to provide, in advance or on-site, countermeasures to prevent morbidity/mortality directly related to operationally induced trauma, such as neuroprotection to decrease brain injury caused by repetitious minor or single event traumatic brain injuries.

Enhancements may involve more equipment-centric capabilities. Many of these “skin-out” capabilities have significant overlap with other capability areas, but represent enhanced physiological capabilities beyond normal human capabilities. Examples include aircraft pressurization and oxygen systems, night vision goggles or “bionic” strength enhancing exoskeletons apparatus.

Provide and Maintain Ability to Operate Across the Full Range of Military Operations. The ability to perform in various environments: flight, kinetic, extreme climates (effects of temperature and altitude); space; underwater; CBRNE; and directed energy.

This capability area involves providing/maintaining/enhancing the ability to operate and perform in the full range of environments. Military expeditionary forces operate or may operate in extreme natural climates (e.g., hot-dry, hot-humid, basic cold, severe cold, high altitude) and man-made hazardous environments, such as the flight environment (characterized by high-G, high-altitude, high noise and vibration, etc.). The range also includes: the toxic industrial environment; the underwater environment; the space environment; and especially military-unique warfare environments such as CBRNE environments and directed energy / kinetic energy threat environments.

Manage Warfighter Performance. The ability to provide a healthy and fit force through effectively predicting, monitoring, evaluating Warfighter performance, and taking appropriate actions to counter Warfighter performance decrement. This includes the ability to observe and measure factors, behaviors, and psycho-motor indicators (from both intrusive and non-intrusive means) for real-time evaluation of performance decrement in self and others relevant to influences upon mission effectiveness. Countermeasures could be pharmacological or non-pharmacological in nature to maintain

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wakefulness, mental acuity, physical performance, psychomotor performance and decision-making ability during varying conditions.

Enhance Psychological Resilience. The ability to enhance DoD expeditionary forces' resistance to, and recovery from, the emotional outcomes of combat, adversity, and trauma; prevent psychological dysfunction; and strengthen protective factors to stress and negative events. This includes activities that support the early detection and management of combat and operational stress reactions (COSR) in order to preserve mission effectiveness and warfighting capabilities and mitigate the adverse physical and psychological consequences of exposure to severe stress. In the deployed setting, the MHS will support the Military Departments' implementation of combat and operational stress control (COSC) policies and programs to enhance readiness, contribute to combat effectiveness, enhance the physical and mental health of deployed military personnel, and prevent or minimize adverse effects associated with combat and operational stress.

4.1.2 Provide a Healthy and Fit Force (Health and Wellness)

The ability to provide and enhance a healthy and fit force from accession to veteran includes optimizing health/fitness of peacetime forces, maintaining health/fitness of deployed forces, and restoring the physical and mental health of redeployed service members.

Access a Healthy and Fit Force. The ability to obtain a healthy and fit force using appropriate standards for aptitudes and abilities, medical and mental conditions, and physical fitness to select recruits most likely to finish basic training, perform their job, and successfully complete the first term of service (generally 36 months).

Optimize Health and Fitness of the Non-deployed Force. The ability to optimize the health and fitness of military forces while at home station (in garrison) through effective conduct and management of physical fitness and training programs and individual medical readiness requirements. Although unit and individual fitness is a command function, the MHS can provide expertise on physiological concepts.

Optimize Health and Fitness of the Deployed Force. The ability to optimize the health and fitness of deployed military and civilian forces through effective conduct and management of physical fitness, training programs, and individual medical readiness requirements.

Challenges that need to be addressed proactively in the deployed setting include the extreme nutritional and dietary requirements when deployed for lengthy periods on field rations, and mission and location stresses on mental well-being, and the limitations to maintaining current or enhanced physical fitness/readiness standards.

Ensure the Physical and Mental Health of the Redeployed Force. The ability to evaluate and predict physical and mental health effects on a redeployed Warfighter (routine screening and follow-up of immediate and long-term health threats); communicate effective implementation strategies to decision-makers; and provide

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effective communication and accountability systems enabling contact between commanders, their injured Warfighters, and families.

4.1.3 Provide Public Health/Veterinary Services

The ability to provide public health/veterinary service support to DoD expeditionary personnel by performing food safety operations and inspections and providing for the care and physical well-being of military working animals. Additionally, the provision of veterinary and public health services during humanitarian assistance missions is essential to host nation sponsors and adds value to relationships with partner nations.

Provide Food Safety and Inspections. The ability to assess wholesomeness and safety of locally available foodstuffs to determine fitness for DoD expeditionary personnel consumption. Used in conjunction with preventive medicine capabilities, proper food and water safety and inspections ensure that deployed forces receive the best and safest food and water available in theater. In remote or austere settings, food and water safety and inspections also are performed on foreign food production and supply chain distribution facilities using Food and Drug Administration (FDA) standards in a continuous quality program.

Provide Military Working Animal Care. The ability to provide medical services and healthcare to military working animals in theater to enhance FP through detection of drugs and explosives for base and physical security.

Provide Health-Related Education. The ability to effectively educate DoD expeditionary personnel and other beneficiaries to prevent not only the incidence of injury, disease, chronic and acute illness but also secondary and tertiary prevention efforts to facilitate the rapid return of personnel to duty. Health education is provided to improve and sustain health and is often aligned with health risk communication actions.

This ability supports activities under the concept of “capacity building” preventive medicine support in delivering culturally sensitive education and training in the areas of individual, family, and community health and health promotion support. This may include disease prevention (interim monitoring and reporting of health risks and subsequent control of risks through prevention and countermeasure actions) until local pre-conflict or event health care standards are achieved. Actions are taken in an "enabling collaborative environment where the stakeholders participate to improve and/or enhance the capabilities of health care system" to stabilize and enhance the local health care sector to reach minimally effective levels.

This ability supports activities under the concept of preventive medicine support to stability operations or stabilization or reconstruction of public health services to populations. Activities include the ability to evaluate, advise, or assist (as part of a multifunctional or multinational response) in reconstituting or improving effectiveness of preventive medicine services of victimized host, adjoining, or supporting regions/nations. This includes consequence management of adverse health effects of terrorist/combat activities or natural events. It includes assistance to another country or region in the

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restoration of the health care sector in order to provide culturally sensitive health care to their population in accordance with local pre-conflict or event health care standards.

Provide Public Health Sanitation, Control of Disease Vectors, and Other Health Threats. The ability to ensure that personnel are afforded the safest environment possible in which to work and live that promotes health and well-being.

4.1.4 Non-Clinical Preventive Medicine/Health Surveillance

The ability to provide comprehensive and continuous military non-clinical preventive medicine and comprehensive health surveillance to effect early intervention and control strategies for all occupational and environmental health (OEH) hazards and CBRNE threats, using joint technologies, practices, and procedures consistently across the military services.

Provide Comprehensive Health Surveillance. The ability to provide occupational and environmental health surveillance (OEHS), medical surveillance, and health surveillance are important components of comprehensive health surveillance.

Surveillance includes the ability to identify health threats through timely, reliable integrated and expeditionary threat identification capabilities at the levels of the individual Warfighter; small line units; preventive medicine assets; theater medical treatment assets; theater clinical / public health / preventive medicine/ bio-environmental engineering laboratory assets; and reach-back to Service-level laboratory services. It also includes collection of health surveillance data (environmental, occupational, veterinary and medical) in monitoring health status.

The ability to conduct surveillance and monitoring of mental health problems is important to include as part of a comprehensive health-surveillance program. Combat stress reactions are not clinical disorders but instead are consequences associated with either prolonged exposure to high-demand environments or exposure to single or repeated intense or traumatic events. Optimally, rates of COSR therefore should be collected as a discrete, separate category from neuropsychiatric and disease and non-battle injury rates. This includes the ability for COSC unit personnel to engage in first-hand surveillance activities through: consultation with commanders about surveillance and prevention; identification, and management of COSR in units or individuals; identification of at-risk populations by assessing unit morale, cohesion, and stress levels; evaluation of combat units on a periodic basis or after exceptionally stressful events; and, by the provision of consultation to commanders about end-of-tour and transition training and briefings. Ideally, COSC personnel should use standardized measures to assess the status of units and individuals wherever possible.

The relevance of identified threats depends on the ability to quantify health threats through innovative medical information management systems, integrated expeditionary laboratory services/analysis, and dynamic population analysis and epidemiological, zoonotic, veterinary and toxicological studies/modeling.

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Provide Medical Intelligence Preparation of the Operational Environment (MIPOE). The ability to provide all-source medical intelligence products, including collecting and analyzing information, producing assessments and forecasts, and maintaining databases. These databases should incorporate military and civilian healthcare capabilities, endemic disease, DNBI, and operational exposure guidance (OEG), exposure threats and hazards on a theater and site-specific basis.

Anticipate and Predict Health Threats. The ability to anticipate, predict, and mitigate effects of climate/environment or other OEH threats. This capability relies upon monitoring the health of populations, evaluating disease outbreaks/clusters, and making forecast-based predictions on the effects of the environment and individual influences of the environment on humans or animals.

- **Environmental.** Occupational and environmental health surveillance in garrison and deployed environments will ensure threat and hazard sampling, detection, identification, quantification, risk assessment, and follow-up documentation are performed.
- **Individual human and animal.** Monitoring and surveillance of supported populations enables preventive medicine analysis which informs activities to accomplish medical countermeasures which, in turn, prevent casualties and ensure a fit and healthy deployed force (to include US government (USG) owned animals).

Prediction of health threats is accomplished through the evaluation and integration of health assessments (including fitness testing and preventive dentistry screening), epidemiology studies, and trend analysis. It relies upon medical surveillance activities to capture and analyze patient encounters, animal and zoonotic disease, and OEHS to capture and analyze threats, exposures, and potential exposures. It links medical outcomes captured through medical surveillance; threat and exposure information captured through OEHS; and personnel spatial-temporal information in personnel tracking databases.

Provide Health Risk Evaluation (Characterization). The ability to characterize OEH, hazards to determine whether they constitute a threat to the force, forecast health threats, and conduct exposure assessment are important functions needed for protecting the health of the force and ensuring mission accomplishment.

Provide Health Risk Assessment. (1) The ability to use exposure assessments accomplished for single or multiple health threats and to translate those exposure assessments, using recognized risk assessment methodologies (e.g., the EPA's), into assessments of individual health risk and unit (population) health risk. (2) The ability to understand hazard and exposure assessment results; evaluate and apply threat mitigating actions for preventing and protecting the force using cost-benefit analysis; and clearly communicate risk to the decision-maker to prevent disease and non-battle injury (DNBI).

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Provide Health Risk Communications (Including CBRNE). The ability to effectively communicate important health-related information to key stakeholders (e.g., commanders, supervisors, Service members, civilians, contractors, and family members) in a timely manner.

Provide for Medical Countermeasures. . The ability to minimize the incidence or the severity of disease or illness, including the protection of US personnel against rare or exotic endemic diseases or against CBRNE hazards through the application of timely Immuno- and Chemo-prophylaxis Countermeasures.

Relevant sub-tasks include: ability to establish protection priorities, policies, guidance, standards, and criteria for development and use of medical countermeasures to medical threats in areas of responsibility (AOR); direct the timely delivery of vaccines and chemoprophylaxis for infectious diseases and other threats (includes mass prophylaxis of the force, DoD beneficiaries, and mission essential contractors); and, advise on clinical preventive medicine to accomplish a fit and healthy deployed force (to include USG owned animals) to prevent casualties.

Provide for Non-Medical Countermeasures. The ability to employ non-medical actions or materiel to prevent or control the spread of disease or mitigate the effects of CBRNE related exposure. Non-medical countermeasures may include measures to avoid contact with the threat, or to limit contact with the threat, thus reducing the opportunity for adverse health effects to develop. This is accomplished by actions to mitigate/counter identified contamination (providing policy, guidance, standards and criteria for development and use of direct interventions for personal and unit protective non-medical barrier systems against injury or disease), including but not limited to the following: vectors; Toxic Industrial Material (TIM); physical threats such as heat, cold, altitude, blast and projectile; ionizing and non-ionizing radiation; and other medical or non-medical threats which may render harm (whether fatal or incapacitating) to life, limb or eyesight. This also refers to the capability in the HR CONOPS under casualty management to support medical care in a CBRNE environment and patient decontamination.

Archive and Retrieve Health-Related Documents and Data. The ability to provide effective laboratory and information management systems and procedures for documenting, compiling, storing, and archiving germane non-clinical preventive medicine and health surveillance data, including deployment and in-garrison OEH- and CBRNE-related data in usable and actionable formats that enable retrieval, strategic communication, and future reference. Includes the ability to create longitudinal exposure records which include individual exposures recorded in medical records and archived OEH and CBRNE monitoring data critical for the short- and long-term health protection of the force.

4.1.5 Global Patient Movement

The ability to evacuate injured and ill personnel with appropriate en-route care. This includes all activities related to casualty evacuation (CASEVAC), medical evacuation (MEDEVAC), aeromedical evacuation (AE), en-route care, PM planning, medical

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regulating, patient staging facilities, patient movement items (PMIs), and patient in-transit visibility. Also included are all activities related to maintaining the DoD's Global Patient Movement Network.

Aeromedical Evacuation (AE). The ability to provide movement of regulated patients under medical supervision to and between MTFs by USAF fixed-wing organic or commercial assets. Civil Reserve Air Fleet may also be used.

Casualty Evacuation (CASEVAC). The ability to provide unregulated movement of casualties aboard non-dedicated, non-standardized platforms (vessels, vehicles, or aircraft), including movement to and between MTFs.

En-route Care. The ability to provide continuation of healthcare for critically injured/ill Warfighters accompanied by trained medical providers while being moved to increased medical care capabilities or to a site for final disposition or RTD (JP 1-02). En-route care, which is a shared capability with casualty management, requires detailed coordination, standardization and synchronization. This includes the capability to direct and manage a PM safety program which allows for evaluation of the quality of care standards and process improvement.

Manage Patient Movement Items (PMIs). The ability to manage medical equipment, supplies, and PMIs required to support PM. This includes activities related to managing theater resources, preventive maintenance and repair, and supporting information systems.

Medical Evacuation (MEDEVAC). The ability to provide timely, efficient PM and en-route care of the wounded, injured, or ill persons from the point of injury to an MTF; from one MTF to another MTF; or from an MTF to a contingency aeromedical staging facility (CASF). This is performed by dedicated, standardized MEDEVAC platforms, with trained medical professionals

Medical Regulation. The ability to coordinate intra-theater and inter-theater PM. This includes PM policies, medical regulating authorities, PM requirements centers, supporting information systems and PM enablers such as the Joint Patient Movement Teams.

Patient Movement Planning, C2. The ability to provide command and control for all units involved in PM. The ability to provide PM planning.

Provide Patient Reception, Staging and Re-distribution. The ability to manage patients at staging facilities and provide transitory care. This includes evacuation related activities at casualty collection points, helicopter evacuation stations, AE staging facilities, and the federal coordinating centers.

Staging and Management of Patient Movement Teams. The ability to stage and manage teams and units to sustain, with no degradation, the standards of care as patients move through the continuum of care. This includes activities related to MEDEVAC

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crews, AE crews, critical care air transport teams, aeromedical staging facilities, and specialty care teams such as the Army's Burn Flight Team.

4.1.6 Casualty Management

The ability to provide a continuum of timely, responsive medical and surgical care that incorporates the latest technologies and advancements in medical science. This care begins with the first responder and proceeds through forward/resuscitative care and theater hospitalization in the joint area of operations. Health Service Delivery addresses definitive care at a CONUS-based rehabilitative facility.

First Responder Care. The ability to provide initial medical care at, or near, the point of injury by the individual or medical and/or non-medical personnel. This may include preparing the casualty for transportation to the next medical capability, as required.

Forward Resuscitative Care. The ability to provide expedient healthcare at the point of injury to salvage life, limb, or eyesight and relieve pain. This care includes stabilizing the patient in preparation for transportation to the next higher medical capability, as required.

Organic and Area Medical Support in Theater. The ability to provide resuscitative care, sick call, and patient holding for up to 72 hours within a specified area of operations.

Theater Hospitalization. The ability to provide capabilities that medical personnel require to repair, restore, stabilize, or rehabilitate casualties within the theater, including preparation for strategic transport, return to duty, or rehabilitation. The utilization of telemedicine in this setting is a force multiplier.

Medical Care in a CBRNE Environment. Response in the event of an emergency resulting in casualties generated by WMD, mass casualty incidents, and/or terrorism events including the ability to perform medical operations in a contaminated environment, decontaminate patients, and mitigate CBRNE medical effects.

- **Patient Decontamination** The ability to mitigate/counter identified contamination by ensuring sick injured, wounded, or other persons are safe through the process of absorbing, destroying, neutralizing, making harmless, or removing chemical or biological agents or removing radioactive materials clinging to or around them. Patient decontamination may be required beyond gross decontamination by other agencies to ensure medical and/or dental care or treatment is not compromised; also includes the subsequent decontamination of MHS personnel and equipment which may become exposed and become ineffective for continued patient care.
- **Patient Medical Countermeasures** This capability includes preventive countermeasures such as chemically and biologically hardening and physical protection of medical facilities to prevent contamination and CBRNE effects which delay or compromise safe casualty care.

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4.1.7 Medical Command and Control

The ability to exercise authority and direction over assigned and attached forces in the accomplishment of the mission. Command and control functions are performed through an arrangement of personnel, equipment, communications, facilities, and procedures employed by a commander in planning, directing, coordinating, and controlling forces and operations in the accomplishment of the mission.

Plan Collaboratively. This capability involves an effects-based approach that directly ties offensive actions to campaign objectives, drawing on global resources, and considering global consequences. Planning must be conducted with the collective knowledge of the decisions and plans of others to produce coherent integration. Planners must be able to focus on exploiting critical adversary vulnerabilities and must consider friendly critical capabilities and potential collateral damage. Parallel, distributed, collaborative planning capabilities and improved assessment tools are needed to compress process timelines. However, collaboration does not imply decision-making by committee or consensus. The ability to assess the suitability of a plan through wargaming and mission rehearsal prior to execution is also needed.

Leverage Mission Partners. The ability to achieve and maintain unity of effort and leverage the capabilities of mission partners to coordinate, collaborate, influence, persuade, negotiate and diplomatically achieve synchronization of efforts according to shared information and plans.

Establish/Adapt Lines of Communication and Relationships to Enable Global / Regional Collaboration of all Medical Partners. The ability to quickly establish or adapt command structures across the force and within the staff, tailored to the mission, to create the processes that will enable horizontal and vertical collaboration.

Exercise Medical Management of Seamless Interoperable Medical Operations. The ability to exercise authority and direction by a properly designated commander over assigned and attached forces in order to seamlessly accomplish its mission.

Synchronize Execution Across All Domains. The ability to effectively plan is an essential means of achieving synchronized action, provided the plan remains appropriate to the situation and is executed properly. Medical leaders must be able to achieve synchronization when operations are not executed as planned. This can be done through centralized redirection, as in the past, or in a decentralized manner through self-synchronization of subordinate forces. The latter is the preferred method for future C2, but this approach may not always be feasible or appropriate. Medical leaders must have the ability to employ whichever method of synchronization is appropriate to the situation. Self-synchronization requires subordinates to have a clear understanding of the commander's intent, shared SA and operational trust, good communications, and the ability to act without detailed direction from above.

Monitor Execution, Assess Effects and Adapt Operations. This capability builds upon Capabilities 3 and 4 in particular. Commanders need the ability to maintain SA, assess

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plan execution effectiveness and rapidly update plans by identifying alternative COAs and redirect forces as circumstances change. Commanders and their staffs must have visibility over friendly unit decisions and capabilities, and the ability to monitor and react to changes in adversary status. Planners must be able to predict desirable and undesirable attack consequences and anticipate how effects may propagate throughout an adversary's system. The ability to respond rapidly and effectively to changing circumstances will enable commanders to maintain effective operations.

4.1.8 Shared Situational Understanding and Awareness

The ability to capture and share timely, accurate and interoperable medical data. This data provides medical asset visibility, coordination, and decision support management and enables information-rich visualization and collaborative execution tasks.

Communicate Medical Plan to Support Commander's Intent and Guidance. The ability to share the medical plan, which must address the commander's intent in a concise expression of the operational purpose and desired end state. The medical plan must adapt to changes in the commander's intent and must be shared early and often to enable parallel planning and self-synchronized execution of a seamless medical system.

Develop and Maintain Shared Situational Awareness and Understanding. The ability to access a common operating picture (COP) presenting current and forecast information on adversary and friendly forces, neutral elements, the environment, and geospatial information. This is accomplished through access to both processed and raw data from sensors, analysts and other sources, and through collaborative analysis and assessment of this data. Commanders will ensure that special care and proper procedures be taken in cases involving the transport or transmission of sensitive or classified information. Situational awareness, transformed into knowledge through synthesis, experience and collaboration, will enable situational understanding.

4.1.9 Support to Stability Operations

The ability to provide complementary health capabilities to achieve CCDR security, stability, transition, and reconstruction operations (SSTRO) theater engagement objectives.

4.1.10 Support to Homeland Defense and Civil Support Operations

The ability to provide reinforcing health support to the homeland if the nation were to endure a natural, manmade, or technological catastrophic event.

- Identification of emerging health threats. Through the active monitoring of the environment and medical surveillance systems, interagency coordination and identification of health threats to military forces and the larger population within the homeland are made in a timely enough manner to affect preventative measures or to allow remediation.
- Protection of force health. Establish protection policies, guidance, standards and

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criteria for development and use of medical countermeasures to medical threats in the homeland. Provide vaccines and chemoprophylaxis for infectious diseases (includes mass prophylaxis of the force, DOD beneficiaries, and mission essential contractors).

- Mitigation of health consequences of hostile action. The ability to manage patient care and response in the event of an emergency resulting in casualties generated by WMD, mass casualty incidents, and/or terrorism events including the ability to perform medical operations in a contaminated environment, decontaminate patients, and mitigate CBRNE medical effects.
- Achievement of health preparedness and an adequate response capability. The ability to generate capabilities that medical personnel require to repair, restore, stabilize, or rehabilitate both DoD and non-DoD casualties within the homeland, including preparation for medical evacuation, return to duty, or rehabilitation. Response is coordinated with the USG Interagency and other partners.

4.1.11 Detainee Medical Care

The ability to provide medical care and safeguard the health of detained personnel in compliance with the provisions of the Geneva Convention and our nation's stance on human rights. There are three sub-categories to this topic; presented as three separate tables in Appendix A.

- Detainee Healthcare
- Detainee Emergency Healthcare
- Dental Care

4.1.12 Joint Medical Logistics and Infrastructure Support (JMLIS)

The ability to orchestrate and synchronize the provision of integrated medical logistics capabilities for HR support to the joint force in a designated operational area. This involves the ability to tailor medical logistics capabilities to the needs of the supported force and mission in order to ensure the right medical materiel is available to supply/sustain FHP capabilities and at the right place and time, enabling uninterrupted health care throughout the entire life cycle of joint forces, including pre-deployment, deployment, and red-deployment. The primary functions of JMLIS include:

- Medical Materiel Blood
- Medical Equipment and Technology
- Medical Equipment Maintenance
- Optical
- Medical Facilities
- Medical Logistics Services
- Medical Contract Management

Medical Logistics Integration. The ability to synchronize and integrate the provision of medical logistics for HR support to the joint force in a designated operational area. This

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includes activities to optimize medical logistics operations and sustain clinical operations throughout the JOA.

Medical Logistics Management. The ability to manage and maintain visibility of medical logistics for HR support to the joint force in a designated operational area. This includes activities to develop and sustain shared medical logistics situational awareness to support a dynamic plan to provide medical logistics support to all medical expeditionary functions throughout the JOA.

4.2 RISKS AND MITIGATION ASSOCIATED WITH HR CAPABILITIES

This section addresses three primary potential risks associated with following this concept as opposed to other alternatives. The section does not address the operational risk of failure inherent in conducting any particular mission.

4.2.1 Anticipated Advanced Technologies Will Be Neither Developed Nor Acquired

If anticipated advanced technologies are neither developed nor acquired, the result will be less than optimal HR. The risk may be mitigated by less ambitious operations with acceptance and continuation of training medical forces at all echelons to use currently available technologies.

4.2.2 Increasing Dependence on Information Processes

Systems and technologies add potential vulnerabilities that must be defended. As with any failure of technology, this will require maintaining the ability to conduct HR operations in a less than optimal information environment.

4.2.3 System Inertia

System inertia will forestall attempts to break down service insularity (or stovepipes) to achieve anticipated horizontal and vertical full-spectrum integration. This effort may limit the ability to maximize inter-service synergism and reduce unnecessary redundancies. Increasing joint training and education, with operations focused on future leadership of the MHS community, may mitigate the risk.

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5.0 CHAPTER 5. STRATEGY FOR FORCE HEALTH PROTECTION IMPLEMENTATION

“There will be no moment at which the Department is ‘transformed.’ Rather, we are building a culture of continual transformation, so that our armed forces are always several steps ahead of any potential adversaries. To do so, we must envision and invest in the future today, so we can defend our homeland and our freedoms tomorrow. The Department is up to the task.”

– Former Secretary of Defense Donald H. Rumsfeld

5.1 ROLE OF FORCE HEALTH PROTECTION TRANSFORMATION

Successful transformation of US military forces and DoD processes requires clear objectives. Force Health Protection provides a common lexicon for medical capabilities for supporting service members, their families, and all those individuals entrusted to our care. Effective implementation requires clearly assigned roles and responsibilities.

The effective implementation of the FHP transformation strategy will enable prioritization of transformation investments among capabilities that address future risks and balance against the other risk areas identified in the 2010 QDR and future reviews.

Transformation of FHP is essential to meet challenges of the future and achieve United States’ commitment to a peaceful world. Attaining FHP capabilities and providing MHS forces that accomplish them during joint operations is critical to reaching these goals.

5.2 GUIDANCE FOR IMPLEMENTING MHS TRANSFORMATION

To achieve a true transformation and the breakthrough performance we desire, we must transform our cultural paradigm. Our culture is defined by the assumptions and mental models we use to understand the world and guide our behaviors. We intend to change those assumptions in ways shown in Table 5-1¹⁰.

Table 5-1: Changing the Way We Think and Act

Old Paradigm		New Paradigm
Why should we...	To	Why couldn't we...
Two competing missions: healthcare delivery and force health protection	To	One mission, three interdependent themes
Service-specific infrastructure	To	Jointly staffed facilities
Budget and rules based	To	Performance-based management
End year with no money left	To	End year with savings; meet performance goals
Beneficiary satisfaction surveys	To	Customer relationship building
Provider centered	To	Patient control and accountability
Direct care system of MTFs and network of civilian providers	To	Integrated health delivery team with shared accountability
Proprietary information	To	Data sharing
Fixed-fee contracts	To	Performance-based contracting
Active duty, reserve, guard, civilians, and contractors managed separately	To	Total force and team development

¹⁰ Military Health System Strategic Plan, p. 6, 2008.

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The DoD and MHS continue to pursue transformational business and planning practices such as adaptive planning and a more entrepreneurial future-oriented, capabilities-based resource allocation planning process. They also are pursuing accelerated acquisition cycles built on spiral development, output-based management, and a reformed analytical support agenda. It is imperative that DoD and MHS leadership foster innovation and adaptation of information age technologies and concepts within organizational and functional areas. With increased reliance on civilian-based contract support for delivering medical care, greater attention to the optimization of the direct care system with contractor support must be balanced with a priority of focus directed to the sustainment of expeditionary capabilities.

To this end, the MHS recognizes ongoing DoD efforts in capability and portfolio management and acknowledges that intermittent evaluations are necessary for capturing modifications. To facilitate these processes, an HR Work Group (WG) will operate as a conduit for addressing HR issues and capabilities to the Force Support Functional Capability Board (FS FCB). The HR WG is responsible for organizing, analyzing, and prioritizing HR joint Warfighter capability proposals.

Principal Membership of the HR WG includes representatives from the Services; J-8 Joint Capabilities Division; Assistant Secretary of Defense (Networks and Information Integration) [NII]; Office of the Secretary of Defense (CAPE); Office of the Undersecretary of Defense (Acquisition, Technology, & Logistics) [USD(AT&L)]; Deputy Assistant Secretary of Defense (DASD), Health Budgets and Financial Policy; DASD, Force Health Protection and Readiness; and DASD, Clinical and Program Policy. Advisory members include representatives from J-6 (interoperability advisor); J-8 Joint Capabilities Division; and additional subject matter experts as required.

The HR WG will identify and consider alternatives for joint Warfighter needs in the capability area of HR. The HR WG also is responsible for addressing material and nonmaterial solutions to HR capability gaps, and is the lead coordinating body ensuring HR priorities are appropriately represented through the JCIDS process and existing MHS governance structure.

5.3 INTEGRATION OF FHP ELEMENTS INTO THE MHS OF TOMORROW

The overarching goal of the MHS is casualty prevention and care achieved through a physically and mentally fit force trained for modern combat and supported by a robust medical support system. FHP capabilities have expanded beyond combat medical support and acute care services toward proactive and preventive services that improve the health of service members and address medical threats before casualties occur.

Today's FHP strategy is intended to ensure the health of the forces across the full range of operational contexts. It encompasses the ability to:

- provide preventive measures, diagnosis, and treatment of disease and injury;
- mobilize, deploy, and sustain field medical services and support for any operation requiring military forces;

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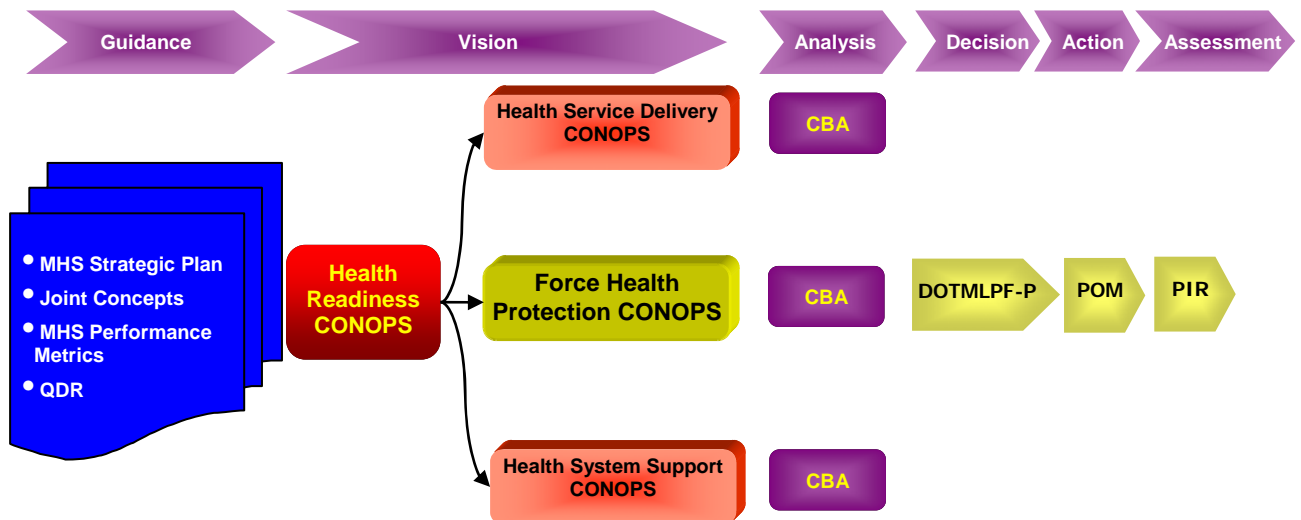
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- maintain and project the continuum of health care resources required to provide for the health of the force;
- operate in conjunction with beneficiary health care;
- maintain an integrated medical surveillance system that covers the full spectrum of care from the first responder to definitive treatment that is tied to both DoD, non-DoD, and Multinational systems; and
- develop training systems for medical personnel that provide realistic rehearsals of emergency medical and surgical procedures and unit-level medical operations.

Force readiness depends on having all Warfighters and support personnel ready to conduct assigned missions and operations. Focused logistics and FHP, within that functional concept, support these aspects of the vision in the near-, mid- and long-term. They translate into formal CBAs, some of which are identified within this document; identification of the needed DOTMLPF changes; and the capabilities the MHS must examine/pursue to achieve the DoD's goal of transformation.

This document sets the stage for the entry of new and existing FHP capabilities into the JCIDS process. The initiatives will follow the construct in Figure 5-1 and be developed under the construct described in the HR CONOPS and integrated with the HSS and HSD CONOPS. The FHP, HSD and HSS functions all fall under FS, Tier II JCA, HR, for conducting CBAs. This process should lead to any required DOTMLPF changes, the development of mission outcome measures, submission of Initial Capabilities Documents (ICD), and follow-on JCIDS documents; allowing the MHS to successfully support the joint Warfighter through 2016 and beyond.

Figure 5-1: Force Health Protection Implementation Plan Structure



5.4 CONCLUSION

Future military operations mandate requirements to project and sustain joint forces conducting distributed simultaneous operations in multiple theaters or locations within theater across the range of military operations including anti-access or area-denial

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situations. Future operations demand adaptable, flexible, and modular forces, responsive, adaptable interagency and multinational partners.

Future FHP capabilities must enable and empower—not delay or disrupt—rapid joint force projection, movement and maneuver, and sustainment anytime and anywhere against all threats and health risks. Comprehensive joint health care support is integral to, and essential in, planning, joint force capability packaging, power projection, sustainment, and redeployment. Ongoing efforts have resulted in the immediate, tangible, and most important benefit of saving lives in the operational environment. Continuing these efforts and expanding them to include reducing sustainment requirements is essential. Developing and deploying capabilities-based networks of interoperable, mutually supported joint forces and systems is the best means of providing comprehensive FHP for future joint military operations.

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APPENDIX A: FHP TASKS, CONDITIONS, AND STANDARDS (T/C/S)

The following data is a result of analyses of contributions from over 300 subject matter experts (SME) involved in the JFHP CBA as reported in the JFHP ICD, Volume II. Additionally, SMEs from across the Services and agencies supporting the respective HR WGs have developed these “Tasks, Conditions, and Standards” as the basis for follow-on studies and analyses.

A.1. Tables of Tasks, Conditions, and Standards (T/C/S)

Each Chapter 4 capability has associated tasks, conditions (“attributes”) and standards using conditions derived from the NDS. Attributes are defined as a testable or measurable characteristic that describes an aspect of a system or capability. Below are the key attributes’ definitions associated with the functional areas. The definitions were based on various sources and then modified for best-fit application to the medical tasks of the respective functional areas.

Table A1. FHP Capability Attributes

Attribute	Definition
Accessible	Readily obtained, used, seen, or known.
Acceptable	Able to satisfy a need, requirement, or standard.
Accurate	Reflecting reality correctly; in exact conformity to fact; errorless.
Adaptable	Able to change or adjust to different circumstances or conditions.
Agile	Able to think or react quickly with acuity and coordination.
Appropriate	Suitable or fitting for a specific purpose or use.
Complete	Whole or intact, with all needed parts and elements.
Comprehensive	Inclusive of all relevant factors, issues, and capabilities.
Decentralized	Possessing lower echelon elements that are empowered to function quickly, independently, or autonomously when appropriate in order to take advantage of short duration opportunities to advance mission accomplishment.
Deployable	Structured in such a way as to be able to be transported to the field environment and rapidly readied for function in accomplishing its mission.
Durable	Able to accomplish its functions over time without significant deterioration.
Effective	Able to produce the intended effect, result, or end state.
Ergonomic	Able to maximize productivity and minimize chronic injury by reducing operator fatigue and discomfort through intelligent workplace equipment design.
Expeditionary	Organized, postured, and capable of rapid deployment, employment, and sustainment.
Flexible	Able to adapt or be modified in order to effectively meet changing conditions or requirements.
Integrated	Composed of elements or parts that function together in a coordinated fashion to achieve unity of effort.
Interchangeable	Capable of substitution without loss of function and effectiveness.

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Attribute	Definition
Interoperable	Composed of systems, capabilities, and organizations that are functional in harmony across all joint force elements. Able to exchange knowledge and services among units and commands at all levels.
Intuitive	Able to be understood accurately through sensing and perception rather than by objective observation and hard, rational logic.
Net-centric	Relating to or representing the attributes of a robust, globally interconnected network environment (including infrastructure, systems, processes, and people) in which data are shared timely and seamlessly among users, applications, and platforms.
Networked	Able to share a common operational picture (COP) and be linked and synchronized electronically in order to increase operational effectiveness through coordinated movement and action.
Practical	Able to use common sense, judgment, and reason to find a simple, direct, and efficient path to the desired end.
Predictive	Capable of knowing or predicting future conditions in order to be prepared to operate effectively when they arrive.
Persistent	Capable of extended functioning in an environment and delivering intended effects—even in adverse circumstances.
Relevant	Able to have a practical, germane, and substantial effect on the matter at hand.
Reliable	Able to be used for an extended time under specified operating conditions without loss of critical function or capability.
Responsive	Able to reply or react or answer to queries or requests with timeliness appropriate to the situation.
Safe	Secure from liability, harm, injury, danger, or risk of mishap or error.
Scalable	Designed to be capable of being modified in magnitude according to the needs of the circumstances.
Secure	The ability to protect or ensure the privacy or secrecy of a system. Implies the ability to guard from danger, risk, or loss from danger or harm and to make safe from penetration or interception by unauthorized persons.
Shared	Held in common (whether conceptually or in electronic or other media) among individuals, groups, or organizations.
Standardized	Conforming to established criteria of size, weight, quality, strength, or functionality to permit substitution without loss of original function.
Synchronized	Functioning in a coordinated fashion with specific actions across multiple agents occurring at the proper time and in the proper sequence.
Tailorable	Able to be modified or adjusted within a certain range to better meet the needs or demands of the circumstances.
Timely	Delivered or performed when needed to be most effective in the situation.
Total Asset Visibility (TAV)	The ability to know the location, functionality, and availability of all required resources, whether human, equipment, supplies, or systems.

The attributes selected are most critical for the respective task with corresponding standards with metrics to provide a standard of measure for evaluating the level of

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success in the future. Although many metrics and attributes were considered, those selected for this appendix are most directly of use in determining the success or failure of task accomplishment.

The “Standards” in most cases are long-term ‘goals.’ Some standards, alternatively, may later be determined to be measures that are too low to adequately drive needed improvements. A broader treatment of the tasks to address either higher level of detail, or an expansion to include implied tasks and measurement of capabilities in the future, would be part of a CBA that would use this appendix as its primary source document. Recommendations resulting from the CBA may include revising the Standards, or developing methods to collect objective measures, establish baselines, and track progress.

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FHP Capability 1.1

Human Performance Optimization Capabilities: Manage Warfighter Fatigue

DESCRIPTION OF CAPABILITY: The ability to evaluate and monitor fatigue, predict and manage effects on Warfighters' performance, and develop methods for countering the effects of fatigue.

Table A2. Manage Warfighter Fatigue

Operational Tasks	Conditions/Attributes	Standard
Predict Warfighter fatigue	Accurate	Predict with 95% accuracy performance relevant to mission capability.
	Reliable	Predict with 95% accuracy performance relevant to mission capability.
	Timely	Predict with 95% accuracy performance relevant to mission capability.
Monitor Warfighter fatigue	Timely	Monitor with 95% accuracy critical performance in real time.
	Acceptable	Monitor with 95% accuracy critical performance in real time.
	Accurate	Maintain mental acuity, physical, psychomotor and decision-making performance without degradation for 72 hours of continuous wakefulness, 95% of the time.
	Comprehensive	Maintain mental acuity, physical, psychomotor and decision-making performance without degradation for 72 hours of continuous wakefulness, 95% of the time.
Evaluate fatigue	Accurate	95% accuracy in evaluation of fatigue factors relevant to mission effectiveness.
	Effective	95% accuracy in evaluation of fatigue factors relevant to mission effectiveness.
	Acceptable	95% accuracy in evaluation of fatigue factors relevant to mission effectiveness.
	Practical	95% accuracy in evaluation of fatigue factors relevant to mission effectiveness.
Counter Warfighter fatigue	Effective	Maintain mental acuity, physical, psychomotor and decision-making performance w/o degrading for 4 consecutive days of partial sleep (less than/equal to 4 hrs per day) or during adverse circadian phase, 95% of the time.
	Acceptable	Maintain mental acuity, physical, psychomotor and decision-making performance without degradation for 24hours of continuous wakefulness, 95% of the time.
	Accurate	100% of personnel are mission effective immediately upon arrival in the JOA.

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Operational Tasks	Conditions/Attributes	Standard
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs).		

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FHP Capability 1.2

Human Performance Optimization Capabilities: Optimize Human-Systems Integration (HSI)

DESCRIPTION OF CAPABILITY: The ability to support integration of the Warfighter (human system) into all systems to sustain or enhance human performance, reduce Warfighter morbidity and mortality, and improve mission performance.

Table A3. Optimize HSI

Operational Tasks	Conditions/Attributes	Standards
Provide human systems integration with weapons systems	Intuitive	All systems will be designed with man-machine interfaces resulting in zero human critical incidents (eg, catastrophic loss to person or machine) / accidents / errors 95% of the time.
	Ergonomic	All systems will be designed with man-machine interfaces resulting in zero human critical incidents (eg, catastrophic loss to person or machine) / accidents / errors 95% of the time.
	Reliable	Human-System Integration is an integral part of 100% of system design and development processes.
	Integrated	Human-System Integration is an integral part of 100% of system design and development processes.
	Safe	Operates within acceptable tolerances 99% of the time.
	Standardized	Human-System Integration is an integral part of 100% of system design and development processes.
Provide human systems integration with command, control, communications and computer systems	Intuitive	All systems will be designed with man-machine interfaces resulting in zero human critical incidents (eg, catastrophic loss to person or machine) / accidents / errors 95% of the time.
	Ergonomic	Human-System Integration is an integral part of 100% of system design and development processes.
	Reliable	Human-System Integration is an integral part of 100% of system design and development processes.
	Safe	Operates within acceptable tolerances 99% of the time.
	Integrated	Human-System Integration is an integral part of 100% of system design and development processes.
Provide human systems	Intuitive	All systems will be designed with

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Operational Tasks	Conditions/Attributes	Standards
integration with vehicles, ships, aircraft and spacecraft		man-machine interfaces resulting in zero human critical incidents (e.g., catastrophic loss to person or machine) / accidents / errors 95% of the time.
	Ergonomic	All systems will be designed with man-machine interfaces resulting in zero human critical incidents (e.g., catastrophic loss to person or machine) / accidents / errors 95% of the time.
	Reliable	Human-System Integration is an integral part of 100% of system design and development processes.
	Integrated	Human-System Integration is an integral part of 100% of system design and development processes.
	Safe	Operates within acceptable tolerances 99% of the time.
	Standardized	Human-System Integration is an integral part of 100% of system design and development processes.
Provide human systems integration with non-weapon systems and individual equipment	Intuitive	All systems will be designed with man-machine interfaces resulting in zero human critical incidents (e.g., catastrophic loss to person or machine) / accidents / errors 95% of the time.
	Ergonomic	All systems will be designed with man-machine interfaces resulting in zero human critical incidents (e.g., catastrophic loss to person or machine) / accidents / errors 95% of the time.
	Reliable	Human-System Integration is an integral part of 100% of system design and development processes.
	Safe	Operates within acceptable tolerances 99% of the time.
	Tailorable	Human-System Integration is an integral part of 100% of system design and development processes.
	Acceptable	Human-System Integration is an integral part of 100% of system design and development processes.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 1.3

Human Performance Optimization Capabilities: Enhance Warfighter Sensory, Cognitive, and Motor Capabilities

DESCRIPTION OF CAPABILITY: The ability to enhance and sustain sensory capabilities (e.g., hearing, speech, vision); manage/control sensory inputs; enhance and sustain cognitive performance; and monitor, assess, and use the physical and mental status of individual Warfighters and units to enhance commanders' decision-making.

Table A4. Enhance Warfighter Sensory, Cognitive, and Motor Capabilities

Operational Tasks	Conditions/Attributes	Standard
Enhance and sustain sensory capabilities	Acceptable	Sustain baseline sensory capability in other-than-optimal operational environments, 95% of the time.
	Reliable	Sustain baseline sensory capability in other-than-optimal operational environments, 95% of the time.
	Accurate	Enhance recognition of sensory stimuli beyond unaided levels, 95% of the time.
	Effective	Enhance recognition of sensory stimuli beyond unaided levels, 95% of the time.
	Adaptable	Enhance recognition of sensory stimuli beyond unaided levels, 95% of the time.
Manage and control sensory inputs	Acceptable	No mission failures due to inappropriate sensory inputs, 95% of the time.
	Effective	No mission failures due to inappropriate sensory inputs, 95% of the time.
	Reliable	No mission failures due to inappropriate sensory inputs, 95% of the time.
	Accurate	No mission failures due to inappropriate sensory inputs, 95% of the time.
	Appropriate	No mission failures due to inappropriate sensory inputs, 95% of the time.
Enhance and sustain cognitive performance	Acceptable	Sustain baseline cognitive capability in other-than-optimal operational environments, 95% of the time.
	Reliable	Sustain baseline cognitive capability in other-than-optimal operational environments, 95% of the time.
	Accurate	Cognitive abilities increased above baseline levels to enhance speed and accuracy of decision-making, 95% of the time.
	Effective	Cognitive abilities increased above baseline levels to enhance speed and accuracy of decision-making, 95% of

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Operational Tasks	Conditions/Attributes	Standard
		the time.
	Adaptable	Cognitive abilities increased above baseline levels to enhance speed and accuracy of decision-making, 95% of the time.
Enhance and sustain physical performance	Acceptable	Sustain baseline physical capability in other-than-optimal operational environments, 95% of the time.
	Reliable	Sustain baseline physical capability in other-than-optimal operational environments, 95% of the time.
	Accurate	Physical abilities increased above baseline levels to enhance speed, strength and endurance, 95% of the time.
	Effective	Physical abilities increased above baseline levels to enhance speed, strength and endurance, 95% of the time.
	Adaptable	Physical abilities increased above baseline levels to enhance speed, strength and endurance, 95% of the time.
Monitor, assess and utilize physical and mental status of individual Warfighters and units to enhance commander's decision-making	Timely	Ability to monitor/assess RT physical and mental status of all troops, 95% of the time.
	Accurate	Ability of commanders to utilize/incorporate RT physical and mental status of all troops into decision-making process, 95% of the time.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 1.4

Human Performance Optimization Capabilities: Enhance Warfighter Learning, Communications and Decision-making

DESCRIPTION OF CAPABILITY: The ability to enhance individual and team learning/training with high retention of knowledge/skills, individual and team communication, SA, and decision-making.

Table A5. Enhance Warfighter Learning, Communications and Decision-making

Operational Tasks	Conditions/Attributes	Standards
Enhance individual and team learning/training with high retention of knowledge/skills	Effective	Increase in training cycle efficiency while maintaining subject detail, 95% of the time.
	Appropriate	No mission failures due to lack of an individual's critical information retention, 95% of the time.
	Responsive	No mission failures due to lack of a team's critical information retention, 95% of the time.
	Tailorable	No mission failures due to lack of a team's critical information retention, 95% of the time.
Enhance individual and team communication	Effective	No mission failures due to lack of an individual's critical communication, 95% of the time.
Enhance situational awareness (SA)	Accurate	No mission failures due to lack of an individual's SA, 95% of the time.
	Comprehensive	No mission failures due to lack of a team's SA, 95% of the time.
	Tailorable	No mission failures due to lack of a leader's SA, 95% of the time.
	Timely	No mission failures due to lack of a leader's SA, 95% of the time.
	Effective	No mission failures due to lack of a leader's SA, 95% of the time.
Enhance decision-making	Timely	No mission failures due to an individual's flawed or untimely decision-making, 95% of the time.
	Effective	No mission failures due to a team's flawed or untimely decision-making, 95% of the time.
	Accurate	No mission failures due to a leader's flawed or untimely decision-making, 95% of the time.
	Complete	No mission failures due to a leader's flawed or untimely decision-making, 95% of the time.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs).		

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FHP Capability 1.5

Human Performance Optimization Capabilities: Enhance Physiological Capability

DESCRIPTION OF CAPABILITY: The ability to improve Warfighter success within the physiological domain to decrease brain injury (neuroprotection), manipulate metabolic processes (related to water intake, nutrition, and waste production), and enhance the ability to withstand trauma and maintain enhanced performance despite military operations.

Table A6. Enhance Physiological Capability

Operational Tasks	Conditions/Attributes	Standards
Provide neuroprotection to decrease traumatic brain injury (TBI)	Acceptable	Decreased morbidity/mortality rate directly related to TBI, 95% of the time.
	Reliable	Decreased morbidity/mortality rate directly related to TBI, 95% of the time.
	Effective	Decreased morbidity/mortality rate directly related to TBI, 95% of the time.
Manipulate metabolic processes related to water intake, nutrition and waste production	Acceptable	Maintain operational tempo with reduced/eliminated Class I requirements, 95% of the time.
	Reliable	Maintain operational tempo with reduced/eliminated Class I requirements, 95% of the time.
	Effective	Maintain operational tempo with reduced/eliminated Class I requirements, 95% of the time.
Enhance ability to withstand trauma	Acceptable	Decreased morbidity/mortality related to operationally-induced trauma, 95% of the time.
	Reliable	Decreased morbidity/mortality related to operationally-induced trauma, 95% of the time.
	Effective	Decreased morbidity/mortality related to operationally-induced trauma, 95% of the time.
Maintain and enhance performance despite the physical, social and psychological stressors of military operations	Acceptable	Service member able to perform the mission when subjected to adverse physical stressors, 95% of the time.
	Reliable	Service member able to perform the mission when subjected to adverse social stressors, 95% of the time.
	Effective	Service member able to perform the mission when subjected to adverse psychological stressors, 95% of the time.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 1.6

Human Performance Optimization Capabilities: Provide and Maintain Ability to Operate Across the Full Range of Military Operations

DESCRIPTION OF CAPABILITY: The ability to perform in various environments: flight; kinetic; extreme climates (effects of temperature and altitude); space, underwater; CBRNE; and directed energy.

Table A7. Provide and Maintain Ability to Operate Across the Full Range of Military Operations

Operational Tasks	Conditions/Attributes	Standards
Provide/maintain the ability to perform in a flight environment	Acceptable	Maintain full operational capability in a flight environment, 98% of the time.
	Effective	Maintain full operational capability in a flight environment, 98% of the time.
Provide/maintain the ability to operate in a kinetic and high-explosive threat environment	Acceptable	Maintain full operational capability in a kinetic and high-explosive threat environment, 98% of the time.
	Effective	Maintain full operational capability in a kinetic and high-explosive threat environment, 98% of the time.
	Reliable	Maintain full operational capability in a kinetic and high-explosive threat environment, 98% of the time.
Provide/maintain the ability to operate in extreme climates (temp and altitude)	Acceptable	Maintain full operational capability in extreme climates (temp and altitude), 98% of the time.
	Effective	Maintain full operational capability in extreme climates (temp and altitude), 98% of the time.
	Reliable	Maintain full operational capability in extreme climates (temp and altitude), 98% of the time.
Provide/maintain the ability to operate in space	Acceptable	Maintain full operational capability in a space environment, 95% of the time.
	Effective	Maintain full operational capability in a space environment, 95% of the time.
	Reliable	Maintain full operational capability in a space environment, 95% of the time.
Provide/maintain the ability to operate in flooded, frozen or underwater environments	Acceptable	Maintain full operational capability in an underwater environment, 98% of the time.
	Effective	Maintain full operational capability in an underwater environment, 98% of the time.
	Reliable	Maintain full operational capability in an underwater environment, 98% of the time.

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Provide/maintain the ability to operate in a CBRNE environment	Acceptable	Maintain full operational capability in a CBRNE environment, 95% of the time.
	Effective	Maintain full operational capability in a CBRNE environment, 95% of the time.
	Reliable	Maintain full operational capability in a CBRNE environment, 95% of the time.
Provide/maintain the ability to operate in directed energy environments	Acceptable	Maintain full operational capability in a directed energy environment, 95% of the time.
	Effective	Maintain full operational capability in a directed energy environment, 95% of the time.
	Reliable	Maintain full operational capability in a directed energy environment, 95% of the time.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 1.7

Human Performance Optimization Capabilities: Manage Warfighter Performance

DESCRIPTION OF CAPABILITY: The ability to provide a healthy and fit force through effectively predicting, monitoring, evaluating Warfighter performance, and taking appropriate actions to counter Warfighter performance decrement.

Table A8. Manage Warfighter Performance

Operational Tasks	Conditions/Attributes	Standard
Predict Warfighter performance	Accurate	Predict with 95% accuracy performance relevant to mission capability.
	Reliable	Predict with 95% accuracy performance relevant to mission capability.
	Timely	Predict with 95% accuracy performance relevant to mission capability.
Monitor Warfighter performance	Timely	Monitor with 95% accuracy critical performance in real time.
	Acceptable	Monitor with 95% accuracy critical performance in real time.
	Accurate	Maintain mental acuity, physical, psychomotor and decision-making performance without degradation for 72 hours of continuous wakefulness, 95% of the time.
	Comprehensive	Maintain mental acuity, physical, psychomotor and decision-making performance without degradation for 72 hours of continuous wakefulness, 95% of the time.
Evaluate Warfighter performance	Accurate	95% accuracy in evaluation of performance factors relevant to mission effectiveness.
	Effective	95% accuracy in evaluation of performance factors relevant to mission effectiveness.
	Acceptable	95% accuracy in evaluation of performance factors relevant to mission effectiveness.
	Practical	95% accuracy in evaluation of performance factors relevant to mission effectiveness.
Counter Warfighter performance degradation	Effective	Maintain mental acuity, physical, psychomotor and decision-making performance w/o degradation due to physiological and psychological stressors 95% of the time.
	Acceptable	Maintain mental acuity, physical, psychomotor and decision-making performance without degradation for 72

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Operational Tasks	Conditions/Attributes	Standard
		hours of continuous wakefulness, 95% of the time.
	Accurate	100% of personnel are mission effective immediately upon arrival in the JOA.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 1.8

Human Performance Optimization Capabilities: Enhance Psychological Resilience

DESCRIPTION OF CAPABILITY: The ability to enhance DoD expeditionary personnel resistance to and recovery from the emotional resultant outcome of combat, adversity, and trauma; prevent psychological dysfunction; and strengthen protective factors to stress and negative events.

Table A9. Enhance Psychological Resilience

Operational Tasks	Conditions/Attributes	Standards
Optimize health and fitness of the non-deployed force	Practical	95% of forces meet physical/health requirements for world-wide deployability.
	Acceptable	95% of forces meet current or enhanced physical fitness/readiness standards.
	Effective	95% of forces meet current or enhanced physical fitness/readiness standards.
Routine monitor and assess physical and mental status of individuals to anticipate potential degradation due to current stress and past experiences	Timely	Ability to monitor/assess RT physical and mental status of all troops, 95% of the time.
	Accurate	Ability of commanders to utilize/incorporate RT physical and mental status of all troops into decision-making process, 95% of the time.
Ensure mental health of returned DoD expeditionary personnel	Acceptable	Eliminate long-lasting post-deployment adverse psycho-social effects for 95% of re-deployed forces.
	Effective	Eliminate long-lasting post-deployment adverse psycho-social effects for 95% of re-deployed forces.
	Durable	Eliminate long-lasting post-deployment adverse psycho-social effects for 95% of re-deployed forces.
	Practical	Eliminate long-lasting post-deployment adverse psycho-social effects for 95% of re-deployed forces.
Maintain and enhance performance throughout individuals' careers despite the physical, social and psychological stressors of military operations	Acceptable	Service member able to perform the mission when subjected to adverse physical stressors, 95% of the time.
	Reliable	Service member able to perform the mission when subjected to adverse social stressors, 95% of the time.
	Effective	Service member able to perform the mission when subjected to adverse psychological stressors, 95% of the time.

Reference: Department of Defense *Joint Force Health Protection Initial Capabilities Document (ICD)*, 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)

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FHP Capability 2.1

Provide a Healthy and Fit Force (Health and Wellness): Access a Healthy and Fit Force

DESCRIPTION OF CAPABILITY: The ability to obtain a healthy and fit force using appropriate standards for aptitudes and abilities, medical and mental conditions, as well as physical fitness to select recruits most likely to finish basic training, perform their job, and successfully complete the first term of service.

Table A10. Access a Healthy and Fit Force

Operational Tasks	Conditions/Attributes	Standards
Accession of a Healthy and Fit Force	Effective	Meet 95% of accession standards.
	Practical	Meet 95% of accession standards.
	Predictive	Meet 95% of accession standards.
Collect medical, biological history	Accurate	Collect reliable/verified historical mental acuity, physical, psychomotor and intelligence records.
	Comprehensive	Maintain all available mental, physical, psychomotor and intelligence data.
EHRs tracking starts here To evaluate physical and mental injury and treatment records	Accurate	Collect reliable/verified historical mental acuity, physical, psychomotor and intelligence records.
	Comprehensive	Maintain all available mental, physical, psychomotor and intelligence data.
Remedial programs to raise condition of potential accessions to meet military standards	Effective	Meet 95% of accession standards.
	Practical	Meet 95% of accession standards.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 2.2

Provide a Healthy and Fit Force (Health and Wellness): Optimize Health and Fitness of the Peacetime Force

DESCRIPTION OF CAPABILITY: The ability to optimize the health and fitness of military forces during peacetime or while at home station through effective conduct and management of physical fitness and training programs and individual medical readiness requirements.

Table A11. Optimize Health and Fitness of the Peacetime Force

Operational Tasks	Conditions/Attributes	Standards
Optimize health and fitness of the non-deployed force	Practical	95% of forces meet physical/health requirements for world-wide deployability.
	Acceptable	95% of forces meet current or enhanced physical fitness/readiness standards.
	Effective	95% of forces meet current or enhanced physical fitness/readiness standards.
Sustain and evaluate knowledge and education on nutrition, physical conditioning and healthy lifestyle/behaviors	Practical	95% of forces meet physical/health requirements for world-wide deployability.
	Acceptable	95% of forces meet current or enhanced physical fitness/readiness standards.
	Effective	95% of forces meet current or enhanced physical fitness/readiness standards.
Maintain current immunizations and annual Health Assessments	Appropriate	Meets requirements during pre-deployment processing 99% of the time.
	Reliable	Maintains designed functionality 99% of the time.
	Safe	Operates within acceptable tolerances 99% of the time.
	Comprehensive	Sufficiently meets mission requirements 99% of the time.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 2.3

Provide a Healthy and Fit Force (Health and Wellness): Optimize Health and Fitness of the Deployed Force.

DESCRIPTION OF CAPABILITY: The ability to optimize the health and fitness of deployed military and civilian personnel through effective conduct and management of physical fitness and training programs and individual medical readiness requirements.

Table A12. Optimize Health and Fitness of the Deployed Force

Operational Tasks	Conditions/Attributes	Standards
Maintain or enhance health and fitness of deployed forces	Practical	95% of forces maintain current or enhanced physical fitness/readiness standards during deployment.
	Acceptable	95% of forces maintain current or enhanced physical fitness/readiness standards during deployment.
	Effective	98% of forces available and combat effective.
	Tailable	98% of forces available and combat effective.
Apply all PH and preventive medicine countermeasures	Appropriate	Sufficiently meets mission requirements 99% of the time.
	Reliable	Maintains designed functionality 99% of the time.
	Safe	Operates within acceptable tolerances 99% of the time.
Fitness facilities and regimens for deployed forces tailored to deployed environment	Practical	95% of forces maintain current or enhanced physical fitness/readiness standards during deployment.
	Acceptable	95% of forces maintain current or enhanced physical fitness/readiness standards during deployment.
	Effective	98% of forces available and combat effective.
	Tailable	98% of forces available and combat effective.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 2.4

Provide a Healthy and Fit Force (Health and Wellness): Ensure the Physical and Mental Health of the Redeployed Force.

DESCRIPTION OF CAPABILITY: The ability to evaluate and predict physical and mental health effects on a redeployed Warfighter (routine screening and follow-up of immediate and long-term health threats); communicate effective implementation strategies to decision-makers; and provide effective communication and accountability systems enabling contact between commanders, their injured Warfighters, and families.

Table A13. Ensure the Physical and Mental Health of the Redeployed Force

Operational Tasks	Conditions/Attributes	Standards
Ensure physical and mental health of returned Warfighters	Acceptable	Eliminate long-lasting post-deployment adverse psycho-social effects for 95% of re-deployed forces.
	Effective	Eliminate long-lasting post-deployment adverse psycho-social effects for 95% of re-deployed forces.
	Durable	Eliminate long-lasting post-deployment adverse psycho-social effects for 95% of re-deployed forces.
	Practical	Eliminate long-lasting post-deployment adverse psycho-social effects for 95% of re-deployed forces.
Detailed post-deployment surveys and follow-up surveys and assessments	Accurate	Collect reliable/verified historical mental/emotional, physical, psychomotor, intelligence and performance records.
	Comprehensive	Maintain and evaluate all available mental, physical, psychomotor and intelligence/performance records on re-occurring basis.
Establish routine programs to support post-deployment adjustments for all redeployed forces	Acceptable	Eliminate long-lasting post-deployment adverse psycho-social and physical effects for 95% of re-deployed forces.
	Effective	Eliminate long-lasting post-deployment adverse psycho-social and physical effects for 95% of re-deployed forces.
	Durable	Eliminate long-lasting post-deployment adverse psycho-social and physical effects for 95% of re-deployed forces.
	Practical	Eliminate long-lasting post-deployment adverse psycho-social and physical effects for 95% of re-deployed forces.
Restore/enhance health and fitness of casualties	Acceptable	Restore non-fatal casualties to pre-injury capabilities (return-to-duty vs. medically discharged), 95% of the time.
	Effective	Restore non-fatal casualties to pre-injury capabilities (return-to-duty vs.

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		medically discharged), 95% of the time.
	Durable	Restore non-fatal casualties to pre-injury capabilities (return-to-duty vs. medically discharged), 95% of the time.
	Deployable	Restore non-fatal casualties to pre-injury capabilities (return-to-duty vs. medically discharged), 95% of the time.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 3.1

Provide Public Health/Veterinary Services: Provide for Risk Assessment of Food Safety Threats

DESCRIPTION OF CAPABILITY: The ability to effectively provide food safety and security.

Table A14. Provide Food Safety and Inspections

Operational Tasks	Conditions/ Attributes	Standards
1. Provide for risk assessment of food safety hazards 2. Provide for risk assessment of food and security hazards 3. Assess food source serviceability 4. Assess food safety and security during transport, storage, preparation and serving.	Complete	70% of pertinent data, information, etc., is included with respect to the domain in question
	Useable	Important or applicable 99% of the time
	Reliable	Maintains designed functionality 99% of the time
	Timely	Risk assessments are delivered to decision-maker in time for them to take appropriate action 99% of the time
Anticipate, predict and detect health threats	Compatible	Useable by 99% of the Communities of Interest (COI)
	Reliable	Maintains designed functionality 99% of the time
	Timely	Decision/actions meet requirements 99% of the time
References: Joint Publication, JP 3-28, Civil Support. 14 September 2007 Joint Publication, JP 4-03, Joint Bulk Petroleum and Water Doctrine, 09 December 2010 Department of Defense Directive (DoDD) 6490.02E, Comprehensive Health Surveillance, October 21, 2004 Department of Defense Directive (DoDD) 6200.04, Force Health Protection, October 9, 2004 Department of Defense Directive (DoDD) 6200.05, Force Health Protection (FHP) Quality Assurance (QA) Program, February 16, 2007		

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FHP Capability 3.2

Provide Public Health/Veterinary Services: Provide Military Working Animal Care

DESCRIPTION OF CAPABILITY: The ability to provide medical services and healthcare to military working animals and contract animals employed by the military in theater..

Table A15. Provide Military Working Animal Care

Operational Tasks	Conditions/Attributes	Standards
Provide veterinary services	Complete	99% of required care is provided
	Effective	Produces desired outcomes 99% of the time
	Reliable	Maintains designed functionality 99% of the time
	Timely	Decisions/actions meet requirements 99% of the time
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs).		

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FHP Capability 3.3

Provide Public Health/Veterinary Services: Provide Health-Related Education

DESCRIPTION OF CAPABILITY: The ability to effectively educate DoD personnel and other beneficiaries to prevent not only the incidence of injury, disease, and chronic illness but also secondary and tertiary prevention efforts to facilitate the rapid return of personnel to duty. Health education is provided to improve and/or sustain health and is often aligned with health risk communication actions.

Table A16. Provide Health-Related Education

Operational Tasks	Conditions/Attributes	Standards
Provide occupational health services	Complete	95% of applicable data, information, etc., is included with respect to the domain in question.
	Deployable	Appropriately deployed, employed, and sustained 95% of the time.
	Flexible	Able to meet 95% of mission changes with existing resources.
	Reliable	Maintains designed functionality 99% of the time all standards 99%.
Provide for risk communication	Accurate	99% error free.
	Appropriate	Sufficiently meets mission requirements 99% of the time.
	Effective	Produces desired outcomes 99% of the time.
	Timely	Decisions/actions meet requirements 99% of the time.
References: Joint Publication, JP 3-28, Civil Support, 14 September 2007 Joint Publication, JP 4-03, Joint Bulk Petroleum and Water Doctrine, 09 December 2010 Department of Defense Directive (DoDD) 6490.02E, Comprehensive Health Surveillance, October 21, 2004 Department of Defense Directive (DoDD) 6200.04, Force Health Protection, October 9, 2004 Department of Defense Directive (DoDD) 6200.05, Force Health Protection (FHP) Quality Assurance (QA) Program, February 16, 2007		

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FHP Capability 3.4

Provide Public Health/Veterinary Services: Provide Public Health Sanitation, Control of Disease Vectors, and Other Health Threats

DESCRIPTION OF CAPABILITY: The ability to ensure that personnel are afforded the safest environment possible in which to work and live that promotes health and well-being. The ability to identify hazardous situations and implement mitigation strategies to reduce risk to populations.

Table A17. Provide Public Health Sanitation, Control of Disease Vectors, and Other Health Threats

Operational Tasks	Conditions/Attributes	Standards
Detect health threats	Timely	Decision/actions meet requirements 99% of the time.
	Reliable	Maintains designed functionality 99% of the time.
	Complete	Applicable data, information, etc., is included with respect to the domain in question 99% of the time..
	Deployable	Appropriately deployed, employed, and sustained 99% of the time.
Control vectors (fauna and flora) which create unhealthy, unsafe and disease proliferating effects	Timely	Decision/actions meet requirements 99% of the time.
	Reliable	Maintains designed functionality and efficiency 99% of the time.
	Complete	Applicable data, information, etc., is included with respect to the domain in question 99% of the time
	Deployable	Appropriately deployed, employed, and sustained 99% of the time.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 4.1

Non-Clinical Preventive Medicine/Health Surveillance: Provide Comprehensive Health Surveillance

DESCRIPTION OF CAPABILITY: The ability to provide OEHS, medical surveillance, and health surveillance are important components of comprehensive health surveillance.

Table A18. Provide Comprehensive Health Surveillance

Operational Tasks	Conditions/Attributes	Standards
Detect health threats	Timely	Decisions/Actions meet requirements 99% of the time.
	Reliable	Maintains designed functionality 99% of the time.
	Complete	Applicable data, information, etc. is included with respect to the domain in question 99%.of the time
	Deployable	Appropriately deployed, employed, and sustained (99% of the time.
Identify health threats added:	Complete	99% of applicable data, information, etc., is included with respect to the domain question.
	Deployable	Appropriately deployed, employed, and sustained 99% of the time.
	Reliable	Maintains designed functionality 99% of the time.
	Timely	Decisions/actions meet requirements 99% of the time.
Quantify health threats added	Reliable	Maintains designed functionality 99% of the time.
	Timely	Decisions/actions meet requirements 99% of the time.
	Deployable	Appropriately deployed, employed, and sustained 99% of the time.
Monitor health status of populations	Accurate	99% error free.
	Complete	99% of applicable data, information, etc., is included with respect to the domain question.
	Accessible	Available when needed to meet mission requirements 99% of the time.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 4.2

Non-Clinical Preventive Medicine/Health Surveillance: Provide Medical Intelligence Preparation of the Operational Environment (MIPOE)

DESCRIPTION OF CAPABILITY: The ability to provide all-source medical intelligence products, including collecting and analyzing information, producing assessments and forecasts, and maintaining databases. These databases should incorporate military and civilian healthcare capabilities, endemic disease, and OEH OEG exposure threats and hazards on a theater- and site-specific basis.

Table A19. Provide MIPOE

Operational Tasks	Conditions/Attributes	Standards
Define medical/OEH intelligence requirements	Complete	99% of identified requirements are entered into appropriate intelligence database for collection and production.
	Effective	99% of requirements are tasked for production or collection..
Produce medical/OEH assessments	Accessible	Available when needed to meet mission requirements 99% of the time.
	Reliable	Maintains design functionality 99% of the time.
	Flexible	Able to meet 99% of mission changes with existing resources.
	Timely	Decision/actions meet requirements 99% of the time.
Integrate medical/OEH intelligence products into the intelligence preparation of the battlespace (IPB)	Accurate	99% error free.
	Reliable	Maintains design functionality 99% of the time.
	Timely	Decision/actions meet requirements 99% of the time.
References: Joint Publication, JP 3-28, Civil Support, 14 September 2007 Joint Publication, JP 4-03, Joint Bulk Petroleum and Water Doctrine, 09 December 2010 Department of Defense Directive (DoDD) 6490.02E, Comprehensive Health Surveillance, October 21, 2004 Department of Defense Directive (DoDD) 6200.04, Force Health Protection, October 9, 2004 Department of Defense Directive (DoDD) 6200.05, Force Health Protection (FHP) Quality Assurance (QA) Program, February 16, 2007		

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FHP Capability 4.3

Non-Clinical Preventive Medicine/Health Surveillance: Anticipate and Predict Health Threats

DESCRIPTION OF CAPABILITY: The ability to anticipate and predict health threats to mitigate effects of climate/environment or other OEH threats.

- **Environmental.** Occupational and environmental health surveillance, in homebase operations and deployed environments, will ensure threat and hazard sampling, detection, identification, quantification, risk assessment and follow-up documentation is performed to include air, water, and soil. Outputs will be available to all in the decentralized demand network of joint health support operations.
- **Individual Human and Animal.** Provision of clinical preventive medicine to accomplish a fit and healthy deployed force (to include USG owned animals) to prevent casualties.

Table A20. Anticipate and Predict Health Threats

Operational Tasks	Conditions/Attributes	Standards
Monitor outbreaks / clusters	Accurate	99% error free
	Timely	Decision/actions meet requirements 99% of the time.
	Accessible	Available when needed to meet mission requirements 99% of the time.
	Complete	99% of applicable data, information, etc., is included with respect to the domain in question.
Forecast outbreaks / clusters	Timely	Decision/actions meet requirements 99% of the time.
	Accessible	Available when needed to meet mission requirements 99% of the time.
	Reliable	Maintains designed functionality 99% of the time.
Environmental	Reliable	Maintains design functionality 99% of the time.
	Timely	Decisions/actions meet requirements 99% of the time.
Individual human and animal	Complete	99% of applicable data, information, etc., is included with respect to the domain in question.
	Usable	Important or applicable 99% of the time.
	Reliable	Maintains designed functionality 99% of the time.

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References:

Joint Publication, JP 3-28, Civil Support, 14 September 2007

Joint Publication, JP 4-03, Joint Bulk Petroleum and Water Doctrine, 09 December 2010

Department of Defense Directive (DoDD) 6490.02E, Comprehensive Health Surveillance, October 21, 2004

Department of Defense Directive (DoDD) 6200.04, Force Health Protection, October 9, 2004

Department of Defense Directive (DoDD) 6200.05, Force Health Protection (FHP) Quality Assurance (QA) Program, February 16, 2007

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FHP Capability 4.4

Non-Clinical Preventive Medicine/Health Surveillance: Provide Health Risk Evaluation (Characterization)

DESCRIPTION OF CAPABILITY: The ability to characterize OEH, including infectious disease, endemic disease, environmental contamination, physical hazards, and CBRNE hazards to determine if they constitute a threat to the force. Forecasting health threats, and conducting exposure assessment are important functions for protecting the health of the force to ensure mission accomplishment.

Table A21. Provide Health Risk Evaluation (Characterization)

Operational Tasks	Conditions/Attributes	Standards
Anticipate and predict health threats	Reliable	Maintains design functionality 99% of the time.
	Timely	Decisions/actions meet requirements 99% of the time.
Detect health threats	Timely	Decision/actions meet requirements 99% of the time.
	Reliable	Maintains designed functionality 99% of the time.
	Complete	Applicable data, information, etc., is included with respect to the domain in question 99% of the time.)
	Deployable	Appropriately deployed, employed, and sustained 99% of the time.
Identify health threats through laboratory services and geographic-based disease threats and trends analysis, including biochemical hazards	Complete	99% of applicable data, information, etc., is included with respect to the domain in question.
	Deployable	Appropriately deployed, employed, and sustained 99% of the time.
	Reliable	Maintains designed functionality 99% of the time.
	Timely	Decision/actions meet requirements 99% of the time.
Evaluate health threats	Complete	99% of applicable data, information, etc., is included with respect to the domain in question.
	Reliable	Maintains designed functionality 99% of the time.
	Timely	Decisions/actions meet requirements 99% of the time.
References: Joint Publication, JP 3-28, Civil Support, 14 September 2007 Joint Publication, JP 4-03, Joint Bulk Petroleum and Water Doctrine, 09 December 2010 Department of Defense Directive (DoDD) 6490.02E, Comprehensive Health Surveillance, 21 Oct 04 Department of Defense Directive (DoDD) 6200.04, Force Health Protection, October 9, 2004 Department of Defense Directive (DoDD) 6200.05, Force Health Protection (FHP) Quality Assurance (QA) Program, February 16, 2007		

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FHP Capability 4.5

Non-Clinical Preventive Medicine/Health Surveillance: Provide Health Risk Assessment

DESCRIPTION OF CAPABILITY: (1) The ability to use exposure assessments accomplished for single or multiple health threats and to translate those exposure assessments, using recognized risk assessment methodologies (e.g., the EPA's), into assessments of individual health risk and unit (population) health risk. (2) The ability to understand hazard and exposure assessment results; evaluate and apply threat mitigating actions for preventing and protecting the force using cost-benefit analysis; and clearly communicate risk to the decision-maker to prevent DNBI.

Table A22. Provide Health Risk Assessment

Operational Tasks	Conditions/Attributes	Standards
Provide for risk assessment	Complete	99% of applicable data, information, etc., is included with respect to the domain in question.
	Usable	Important or applicable 99% of the time.
	Reliable	Maintains designed functionality 99% of the time.
	Timely	Decisions/actions meet requirements 99% of the time.
Forecast outbreak /clusters	Timely	Decision/actions meet requirements 99% of the time.
	Accessible	Available when needed to meet mission requirements 99% of the time.
	Reliable	Maintains designed functionality 99% of the time.
References: Joint Publication, JP 3-28, Civil Support, 14 September 2007 Joint Publication, JP 4-03, Joint Bulk Petroleum and Water Doctrine, 09 December 2010 Department of Defense Directive (DoDD) 6490.02E, Comprehensive Health Surveillance, October 21, 2004 Department of Defense Directive (DoDD) 6200.04, Force Health Protection, October 9, 2004 Department of Defense Directive (DoDD) 6200.05, Force Health Protection (FHP) Quality Assurance (QA) Program, February 16, 2007		

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FHP Capability 4.6

Non-Clinical Preventive Medicine/Health Surveillance: Provide Health Risk Communications (Including CBRNE)

DESCRIPTION OF CAPABILITY: The ability to effectively communicate important health-related information to key stakeholders (e.g., commanders and supervisors, service members, government civilians, contractors, and family members) in a timely manner.

Table A23. Provide Health Risk Communications (Including CBRNE)

Operational Tasks	Conditions/Attributes	Standards
Provide for risk communication	Accurate	99% error free.
	Appropriate	Sufficiently meets mission requirements 99% of the time.
	Effective	Produces desired outcomes 99% of the time.
	Timely	Decisions/actions meet requirements 99% of the time.
Document medical information	Complete	99% of applicable data, information, etc. is complete.
	Accurate	99% error free.
	Reliable	Maintains designed functionality 99% of the time.
Report medical information	Reliable	Maintains designed functionality 99% of the time.
	Timely	Decisions/actions meet requirements 99% of the time.
	Networked	Systems and processes link and synchronize capabilities 99% of the time.
	Secure	No compromise of information that impairs current operational effectiveness. No compromise of classified or medical information.
	Complete	99% of applicable data, information, etc., is complete.
References: Joint Publication, JP 3-28, Civil Support, 14 September 2007 Joint Publication, JP 4-03, Joint Bulk Petroleum and Water Doctrine, 09 December 2010 Department of Defense Directive (DoDD) 6490.02E, Comprehensive Health Surveillance, October 21, 2004 Department of Defense Directive (DoDD) 6200.04, Force Health Protection, October 9, 2004 Department of Defense Directive (DoDD) 6200.05, Force Health Protection (FHP) Quality Assurance (QA) Program, February 16, 2007		

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FHP Capability 4.7

Non-Clinical Preventive Medicine/Health Surveillance: Provide for Medical Countermeasures

DESCRIPTION OF CAPABILITY: The ability to minimize the incidence or the severity of disease or illness, including the protection of US personnel against rare or exotic diseases or against CBRN hazards through the application of medical countermeasures. Includes the ability to provide timely Immuno- and Chemoprophylaxis (preventive) Countermeasures.

- **Expeditionary Immunizations.** The ability to employ medical actions or materiel to prevent or control spread of disease or mitigate the effects of CBRNE related exposure. Non-medical countermeasures may include measures to avoid contact with the threat or to limit contact with the threat, thus reducing the opportunity for adverse health effects to develop.

Table A24. Provide for Medical Countermeasures

Operational Tasks	Conditions/Attributes	Standards
Integrate medical/OEH intelligence products into the intelligence preparation of the battlespace (IPB)	Accurate	99% error free.
	Reliable	Maintains design functionality 99% of the time.
	Timely	Decision/actions meet requirements 99% of the time.
Provide occupational health services	Complete	95% of applicable data, information, etc., is included with respect to the domain in question.
	Deployable	Appropriately deployed, employed, and sustained 95% of the time.
	Flexible	Able to meet 95% of mission changes with existing resources.
	Reliable	Maintains designed functionality 99% of the time all standards 99%.
Provide for immuno-and chemoprophylaxis	Appropriate	Sufficiently meets mission requirements 99% of the time.
	Reliable	Maintains designed functionality 99% of the time.
	Safe	Operates within acceptable tolerances 99% of the time.
	Timely	Decisions/actions meet requirements 99% of the time.
Provide for preventive medicine countermeasures	Appropriate	Sufficiently meets mission requirements 99% of the time.
	Reliable	Maintains designed functionality 99% of the time.
	Effective	Produces desired outcomes 99% of the time.
	Safe	Operates within acceptable tolerances 99% of the time.

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	Timely	Decisions/actions meet requirements 99% of the time.
Provide veterinary services	Complete	99% of applicable data, information, etc., is included with respect to the domain in question.
	Effective	Produces desired outcomes 99% of the time.
	Reliable	Maintains designed functionality 99% of the time.
	Timely	Decisions/actions meet requirements 99% of the time.
Expeditionary immunizations	Appropriate	Sufficiently meets mission requirements 99% of the time.
	Reliable	Maintains designed functionality 99% of the time.
	Safe	Operates within acceptable tolerances 99% of the time.
	Timely	Decisions/actions meet requirements 99% of the time.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 4.8

Non-Clinical Preventive Medicine/Health Surveillance: Provide for Non-Medical Countermeasures

DESCRIPTION OF CAPABILITY: The ability to employ non-medical actions or materiel to prevent or control spread of disease or mitigate the effects of CBRNE related exposure. Non-medical countermeasures may include measures to avoid contact with the threat or to limit contact with the threat, thus reducing the opportunity for adverse health effects to develop.

Table A25. Provide for Non-Medical Countermeasures

Operational Tasks	Conditions/Attributes	Standards
Ensure patient and staff decontamination capabilities are available	Accessible	Available when needed to meet mission requirements 99% of the time.
	Reliable	Maintains design functionality 99% of the time.
	Flexible	Able to meet 99% of mission changes with existing resources.
	Timely	Decision/actions meet requirements 99% of the time.
	Interoperable	Available and seamlessly integrates with all assemblages when needed to meet mission requirements 99% of the time.
Employ and monitor the use of security / safety barriers and protective measures	Effective	Produces desired outcomes 99% of the time.
	Reliable	Maintains designed functionality 99% of the time.
	Timely	Decisions/actions meet requirements 99% of the time.
References: Joint Publication, JP 3-28, Civil Support, 14 September 2007 Joint Publication, JP 4-03, Joint Bulk Petroleum and Water Doctrine, 09 December 2010 Department of Defense Directive (DoDD) 6490.02E, Comprehensive Health Surveillance, October 21, 2004 Department of Defense Directive (DoDD) 6200.04, Force Health Protection, October 9, 2004 Department of Defense Directive (DoDD) 6200.05, Force Health Protection (FHP) Quality Assurance (QA) Program, February 16, 2007		

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FHP Capability 4.9

Non-Clinical Preventive Medicine/Health Surveillance: Archive and Retrieve Health-Related Documents and Data

DESCRIPTION OF CAPABILITY: The ability to provide effective laboratory and information management systems and procedures for documenting, compiling, storing, and archiving germane non-clinical preventive medicine and health surveillance data, including deployment and in-garrison OEH- and CBRNE-related data in usable and actionable formats that enable retrieval, strategic communication, and future reference.

Table A26. Archive and Retrieve Health-Related Documents and Data

Operational Tasks	Conditions/Attributes	Standards
Document medical information	Complete	99% of applicable data, information, etc., is complete.
	Accurate	99% error free.
	Reliable	Maintains designed functionality 99% of the time.
Report medical information	Accurate	99% error free
	Reliable	Maintains designed functionality 99% of the time.
	Secure	No compromise of information that impairs current operational effectiveness. No compromise of classified or medical information.
	Networked	Systems and processes link and synchronize capabilities 99% of the time.
Archive medical information	Complete	99% of applicable data, information, etc., is included with respect to the domain in question.
	Accessible	Available when needed to meet mission requirements 99% of the time.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 5.1

Global Patient Movement: Aeromedical Evacuation (AE)

DESCRIPTION OF CAPABILITY: The ability to provide movement of regulated patients under medical supervision to and between MTFs by USAF fixed-wing organic or commercial assets. Civil Reserve Air Fleet may also be used. (JPM FNA Report)-HR4-4.

Table A27. AE

Operational Tasks	Conditions/ Attributes	Standards
Provide Command and Control	Effective	Provide staff, equipment and training to provide C2 and oversight.
	Deployable	C2 staff and equipment are deployable 100% of the time.
	Synchronized	Plans and staff are compatible with the forces and platforms deployed.
	Networked	Software and communications are established in the theater IAW the COCOM plans.
	Reliable	Medical regulation tools are available and connected to Higher HQ systems.
	Secure	Electronic tools are protected and operated within DoD standards.
Collaboratively develop and support a patient transportation annex in the theater security cooperation plan (TSCP)	Adaptable	Plans are published in the TSCP and exercised on an annual basis.
	Integrated	Plans are published in the TSCP and updated annually.
	Synchronized	Plans are coordinated within the Combatant Commands, Services and Coalition Forces.
Provide resources to equip vehicles, aircraft and/or medical attendants	Comprehensive	Evacuation plans are supported in the Fiscal Year Defense Plan (FYDP) and Program Objective Memorandum (POM) requirements.
	Timely	Resources are available in time to support unique requirements.
Develop en-route care capabilities	Deployable	Assets are deployable in any planned theater of operations.
	Standardized	Staff and treatment protocols are stand across the Services.
	Responsive	Assets are readily available.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 5.2

Global Patient Movement: Casualty Evacuation (CASEVAC)

DESCRIPTION OF CAPABILITY: The ability to provide unregulated movement of casualties aboard non-dedicated, non-standardized platforms (vessels, vehicles, or aircraft), including movement to, and between, MTFs.

Table A28. CASEVAC

Operational Tasks	Conditions/ Attributes	Standards
Transportation and treatment options.	Appropriate	Treatment and evacuation vehicles are available and or adaptable to the situation.
	Expeditionary	First Responders are trained to adapt to any environment and use any means of evacuation safely.
	Timely	Outcomes meet time-specific requirements 95% of the time.
Casualty preparation for movement	Interoperable	Training standards are established jointly across the Services.
	Standardized	First Responders are trained to treat and evacuate.
	Expeditionary	First Responders are trained to treat and prevent further injury during evacuation.
	Effective	First responders are trained and equipped to save life and limb and safely transport casualties preventing further injury.
	Responsive	Casualty is treated and moved saving life, limb, and eyesight.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 5.3

Global Patient Movement: En-route Care

DESCRIPTION OF CAPABILITY: The ability to provide continuation of healthcare for critically injured/ill Warfighters accompanied by trained medical providers while being moved to increased medical care capabilities or to a site for final disposition or RTD. Since en-route care is a shared capability with casualty management, detailed coordination, standardization and synchronization is required.

Table A29. En-route Care

Operational Tasks	Conditions/Attributes	Standards
En-route care during patient movement	Flexible	Ability to configure and/or meet mission requirements 95% of the time.
	Interoperable	Systems are compatible with DoD and VA health care systems.
Standardization	Interoperable	Systems are compatible with DoD and VA health care systems.
	Comprehensive	Equipment and training able to meet 90% of all requirements.
	Flexible	Ability to configure and/or meet mission requirements 95% of the time.
	Standardized	At least 90% of equipment used for en-route care standardized across Services.
Trained crews/ personnel	Deployable	En-route care crews meet deployment standards.
	Interoperable	En-route care crews able to provide care on multiple PM platforms.
	Flexible	Ability to configure and/or meet mission requirements 95% of the time.
References: Department of Defense Instruction (DoDI) 6000.11, Patient Movement, 9 September 1998 Department of Defense Directive (DoDD) 5154.06, Armed Services Medical Regulating, January 12, 2005 Joint Publication, JP 4-02, Doctrine for Health Services Support in Joint Operations, 26 April 1995		

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FHP Capability 5.4

Global Patient Movement: Manage Patient Movement Items

DESCRIPTION OF CAPABILITY: The ability to manage medical equipment, supplies, and PMIs required to support PM. This includes activities related to managing theater resources, preventive maintenance and repair, and supporting information systems.

Table A30. Manage PMIs

Operational Tasks	Conditions/ Attributes	Standards
Procure, sustain and maintain PMI	Complete	All critical data/information are available and accurate in 95% of cases (timely).
	Flexible	Ability to re-configure to meet mission requirements 95% of the time.
Interface within the patient movement request (PMR)	Accurate	Conforming precisely to fact or truth 95% of the time.
	Complete	All critical data/information are available and accurate in 95% of cases (timely).
	Timely	Outcomes meet time-specific requirements 95% of the time.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 5.5

Global Patient Movement: Medical Evacuation (MEDEVAC)

DESCRIPTION OF CAPABILITY: The ability to provide timely, efficient PM and en-route care of the wounded, injured, or ill persons from the point of injury to an MTF; from one MTF to another MTF; or from an MTF to a CASF. This is performed by dedicated, standardized MEDEVAC platforms, with trained medical professionals.

Table A31. MEDEVAC

Operational Tasks	Conditions/ Attributes	Standards
Casualty/ patient movement plan/ network	Appropriate	Evacuation Annex is suitable for the theater of operations.
	Tailorable	Joint force is able to rapidly compose an appropriate force and scale the force to fit the mission 95% of the time.
Develop and resource tactical MEDEVAC vehicles and aircraft	Adaptable	Vehicles and aircraft with crews are adaptable to the geo-location and operation.
	Deployable	Can be deployed in any environment or location 100% of the time.
	Standardized	All elements are standardized within DoD and by NATO standards.
Provide medical personnel to support MEDEVAC's	Agile	Personnel are trained to standard and able to react to any situation.
	Interchangeable	Personnel are trained to a Joint standard in every DoD vehicle and aircraft.
	Standardized	Ensure vehicles and aircraft are staff with trained deployable crews.
	Flexible	Crews are able to adapt to non-stabilized patients.
	Adaptable	Crews are trained to unique theater of operations requirements and evacuation routes and procedures.
References: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs) Department of Defense Instruction (DoDI) 6000.11, Patient Movement, 9 September 1998 Department of Defense Directive (DoDD) 5154.06, Armed Services Medical Regulating, January 12, 2005 Joint Publication, JP 3-0, Doctrine for Joint Operations, 10 September 2001 Joint Publication, JP 4-02, Doctrine for Health Services Support in Joint Operations, 26 April 1995		

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FHP Capability 5.6

Global Patient Movement: Medical Regulation

DESCRIPTION OF CAPABILITY: The ability to coordinate intra-theater and inter-theater PM. This includes PM policies, medical regulating authorities, PM requirements centers, supporting information systems and PM enablers such as the Joint Patient Movement Teams.

Table A32. Medical Regulation

Operational Tasks	Conditions/ Attributes	Standards
Identify need for movement	Decentralized	Each Provider has the capabilities and resources to treat and evacuate.
	Networked	Entered into TRACES/PMR.
	Timely	During Triage.
A standard electronic patient movement request (PMR)	Complete	All critical data/information are available and accurate in 95% of cases (timely).
	Timely	Outcomes meet time-specific requirements 95% of the time.
	Accurate	Conforming precisely to fact or truth 95% of the time.
	Networked	Systems and processes link and synchronize capabilities 95% of the time.
Select transportation and treatment options	Complete	All critical data/information are available and accurate in 95% of cases (timely).
	Timely	Outcomes meet time-specific requirements 95% of the time.
	Networked	Systems and processes link and synchronize capabilities 95% of the time.
Collaboratively develop patient transportation i.e. TRAC2ES etc.	Complete	All critical data/information are available and accurate in 95% of cases (timely).
	Interoperable	All elements of like systems are able to provide services to and accept services from other like systems compliant with DoDI 8551.1 95% of the time.
	Accurate	Conforming precisely to fact or truth 95% of the time.
Provide intra-theater patient regulating	Accessible	All MTFs are able to do intra-theater regulating.
	Interoperable	Intra-theater regulating works seamlessly between Service MTFs.
	Networked	Systems and processes link and synchronize capabilities 95% of the time.

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Operational Tasks	Conditions/ Attributes	Standards
	Standardized	All MTFs use the same system for intra-theater regulating.
Provide inter-theater patient regulating	Accessible	All MTFs are able do inter-theater regulating.
	Interoperable	Inter-theater regulating works seamlessly between Service MTFs.
	Networked	Systems and processes link and synchronize capabilities 95% of the time.
	Standardized	All MTFs use the same system for inter-theater regulating.
Redistribution within CONUS	Accessible	All MTFs are able do CONUS to CONUS regulating.
	Interoperable	CONUS to CONUS regulating works seamlessly between Service MTFs.
	Networked	Systems and processes link and synchronize capabilities 95% of the time.
	Standardized	All MTFs use the same system for CONUS to CONUS regulating.
<p>References:</p> <p>Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i>, 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)</p> <p>Department of Defense Instruction (DoDI) 6000.11, Patient Movement, 9 September 1998</p> <p>Department of Defense Directive (DoDD) 5154.06, Armed Services Medical Regulating, January 12, 2005</p> <p>Joint Publication, JP 4-02, Doctrine for Health Services Support in Joint Operations, 26 April 1995</p> <p>Department of Defense Directive (DoDD) 8551.1, Ports, Protocols, and Services Management (PPSM), August 13, 2004</p>		

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FHP Capability 5.7

Global Patient Movement: Patient Movement Planning, C2

DESCRIPTION OF CAPABILITY: The ability to provide command and control for all units involved in PM. The ability to provide patient movement planning.

Table A33. Patient Movement Planning, C2

Operational Tasks	Conditions/ Attributes	Standards
Develop patient movement annexes to operational plans	Complete	All critical data/information are available and accurate in 95% of cases (timely).
	Interoperable	All elements of relevant systems are able to provide services to and accept services from other systems 95% of the time.
	Flexible	Ability to re-configure to meet mission requirements 95% of the time.
Direct PM within an operating theater.	Interoperable	All elements of relevant systems are able to provide services to and accept services from other systems 95% of the time.
	Complete	All critical data/information are available and accurate in 95% of cases (timely).
	Timely	Outcomes meet time-specific requirements 95% of the time.
	Tailorable	Joint force is able to rapidly compose an appropriate force and scale the force to fit the mission 95% of the time.
Track patients	Complete	All critical data/information are available and accurate in 95% of cases (timely).
	Decentralized	Users at all levels will be able to obtain patient tracking information 95% of the time.
	Timely	Outcomes meet time-specific requirements 95% of the time.
	Accurate	Conforming precisely to fact or truth 95% of the time.
References: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs) Department of Defense Instruction (DoDI) 6000.11, Patient Movement, 9 September 98 Department of Defense Directive (DoDD) 5154.06, Armed Services Medical Regulating, January 12, 2005 Joint Publication, JP 4-02, Doctrine for Health Services Support in Joint Operations, 26 April 1995		

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FHP Capability 5.8

Global Patient Movement: Provide Patient Reception, Staging and Re-distribution

DESCRIPTION OF CAPABILITY: The ability to manage patients at staging facilities and provide transitory care. This includes evacuation related activities at casualty collection points, helicopter evacuation stations, AE staging facilities, and the federal coordinating centers.

Table A34. Provide Patient Reception, Staging and Re-distribution

Operational Tasks	Conditions/ Attributes	Standards
Patient Movement team re-positioning	Interoperable	All elements of relevant systems are able to provide services to and accept services from other systems 95% of the time.
	Complete	All critical data/information are available and accurate in 95% of cases (timely).
	Timely	Outcomes meet time-specific requirements 95% of the time.
	Tailorable	Joint force is able to rapidly compose an appropriate force and scale the force to fit the mission 95% of the time.
Employ a joint reception center (JRC) in theater and CONUS	Flexible	Ability to configure and/or meet mission requirements 95% of the time.
	Interoperable	Able to plug-and-play common capabilities 90% of the time.
	Networked	Systems and processes link and synchronize capabilities 95% of the time.
C2 at staging facilities/ JRC	Effective	C2 able to manage PM staging 95% of the time.
	Shared	Staging and Joint Reception smoothly shared by all Services.
	Synchronized	Patient Movement C2 synchronized with line C2 systems 95% of the time.
Transitory care at staging areas/ JRC	Interoperable	Systems interoperable with the DoD Electronic Health Record.
	Responsive	Able to adjust effectively to changing operational situations.
	Tailorable	Joint force is able to rapidly compose an appropriate force and scale the force to fit the mission 95% of the time.
Standardize training for staff	Adaptable	Training can be provided in all Service training environments.

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Operational Tasks	Conditions/ Attributes	Standards
	Decentralized	Training is modularized and easily exportable to numerous training sites and environments.
	Flexible	Training can be provided in classroom, distance learning, secure and non-secure environments.
References: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs) Department of Defense Instruction (DoDI) 1322.24, Medical Readiness Training, 12 July 2002 Department of Defense Instruction (DoDI) 6000.11, Patient Movement, 9 September 1998 Joint Publication, JP 4-02, Doctrine for Health Services Support in Joint Operations, 26 April 1995		

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FHP Capability 5.9

Global Patient Movement: Staging and Management of Patient Movement Teams

DESCRIPTION OF CAPABILITY: The ability to stage and manage teams and units to sustain, with no degradation, the standards of care as patients move through the continuum of care. This includes activities related to MEDEVAC crews, AE crews, critical care air transport teams, aeromedical staging facilities, and specialty care teams such as the Army's Burn Flight Team.

Table A35. Staging and Management of Patient Movement Teams

Operational Tasks	Conditions/ Attributes	Standards
Sustain the patient movement system by replenishing PMI caches and returning patient movement teams to original locations within the JOA	Complete	All critical data/information/ resources are available and accurate in 95% of cases (timely).
	Timely	Outcomes meet time-specific requirements 95% of the time.
	Responsive	Patient Movement teams able to adjust as the operational picture changes.
Training	Adaptable	Training can be provided in all Service training environments.
	Interoperable	Training can be provided to all Service MOS/NEC equivalents.
	Standardized	Training provided similarly by all Services.
References: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs) Department of Defense Instruction (DoDI) 6000.11, Patient Movement, 9 September 1998 Joint Publication, JP 4-02, Doctrine for Health Services Support in Joint Operations, 26 April 1995 Joint Publication, JP 4-03, Joint Bulk Petroleum and Water Doctrine, 09 December 2010 Joint Publication, JP 4-04, Joint Doctrine for Civil Engineering Support, 27 September 2001 Department of Defense Instruction (DoDI) 1322.24, Medical Readiness Training, 12 July 2002 Department of Defense Instruction (DoDI) 1322.25, Voluntary Education Programs, 5 February 1997 Department of Defense Instruction (DoDI) 1322.26, Development, Management, and Delivery of Distributed Learning, 16 June 2006		

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FHP Capability 6.1

Casualty Management: First Responder Care

DESCRIPTION OF CAPABILITY: The ability to provide initial medical care at or near the point of injury by the individual or medical and/or non-medical personnel. This may include preparing the casualty for transportation to the next medical capability, as required.

Table A36. First Responder Care

Operational Tasks	Conditions/Attributes	Standards
Stabilize	Appropriate	Medical Responder, meets standards 95% of the time.
	Standardized	Non-medical responder with enhanced training (Combat Life Saver), meets standards 85% of the time Non-Medical Response, meets standards 100% of the time.
	Interoperable	All elements of like DoD systems provide services to / accept services from other systems 99% of time.
	Timely	Provide services, products, information, intelligence, and/or knowledge within a desired period 95% of the time.
Communicate	Accurate	99% error free.
	Reliable	Maintains designed functionality 99% of the time.
	Timely	Provide services, products, information, intelligence and/or knowledge within a desired period 95% of the time.
Transport	Appropriate	Sufficiently meets mission requirements 85% of the time.
	Effective	Produces desired outcome 99% of the time.
	Timely	Provide services, products, information, intelligence and/or knowledge within a desired period 95% of the time.
Restore to health	Effective	Produces desired outcome 99% of the time.
	Interoperable	All capabilities are linked and synchronous with a focused effort and unified purpose 99% of the time.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 6.2

Casualty Management: Forward Resuscitative Care

DESCRIPTION OF CAPABILITY: The ability to provide expedient healthcare at the point of injury to salvage life, limb, or eyesight and relieve pain. This care includes stabilizing the Warfighter in preparation for transportation to the next higher medical capability, as required.

Table A37. Forward Resuscitative Care

Operational Tasks	Conditions/Attributes	Standards
Save life, limb, and eyesight (Initial Resuscitation)	Effective	Produces desired outcome 99% of the time.
	Interoperable	All elements of like DoD systems provide services to / accept services from other systems 99% of time.
Communicate	Complete	99% of applicable data/information is complete.
	Networked	Systems and processes link and synchronize capabilities 99% of the time.
	Secure	Information assurance and free from data corruption while denying access to unauthorized persons 99% of the time.
Prepare for transport	Appropriate	Sufficiently meets mission requirements 90% of the time.
	Effective	Produces desired outcome 99% of the time.
	Interoperable	All elements of like DoD systems provide services to / accept services from other systems 99% of time.
	Timely	Provide services, products, information, intelligence, and/or knowledge within a desired period 95% of the time.
Restore to health	Effective	Produces desired outcome 99% of the time.
	Interoperable	All elements of like DoD systems provide services to / accept services from other systems 99% of time.
	Tailorable	Joint force is able to rapidly compose an appropriate force and scale it to fit the mission 95% of the time.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 6.3

Casualty Management: Organic and Area Medical Support in Theater

DESCRIPTION OF CAPABILITY: The ability to provide resuscitative care, sick call, and patient holding for up to 72 hours within a specified area of operations.

Table A38. Organic and Area Medical Support in Theater

Operational Tasks	Conditions/Attributes	Standards
Provide primary care/sick call	Effective	Produces desired outcome 99% of the time.
	Integrated	Medical records are effectively linked with EHR or entered in manual system 99% of the time.
	Accessible	Facilities are within one hour of operating area.
	Adaptable	Can adjust to environment conditions, severity of injuries, and patient volume 90% of the time.
Supply first responders/battalion aid stations	Accurate	Initially treat the patient without error 99% of the time.
	Standardized	Conform to 99% of standards in treatment.
	Deployable	Strategically locate Aid Station within one hour of casualty evacuation 90% of time.
	Timely	Provide services, products, and information etc. within desired time period for 95% of the patients.
	Practical	Able to use common sense, judgment, and reason to find a simple solution to 99% of minor illnesses.
	Accessible	Maintain capacity to treat 20 casualties within 48 hours 95% of the time.
	Flexible	Able to adapt to effectively meet 95% of the changing conditions or requirements.
	Interoperable	All elements are able to provide and accept services with 98% of other DoD systems.
	Decentralized	Function quickly, independently, and autonomously to advance the delivery of first responder health care support 99% of the time.
Provide emergent care services	Timely	Advanced trauma management is emergency care designed to resuscitate and stabilize the patient for evacuation to the next echelon of care.
	Accessible	Provide advanced trauma management for theater operating area.

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Operational Tasks	Conditions/Attributes	Standards
	Reliable	100% of personnel are trained and equipped to provide advanced trauma management to the battlefield casualty.
	Durable	Provide organic trauma management staff to medical platoons and or sections and designate trauma management staff for employment anywhere on the battlefield.
	Flexible	Trauma management staff provides routine sick call when needed.
Integrate with combat and naval units	Deployable	Structured in such a way as to be able to be transported to the theater of operations to maintain presence with the combat and naval unit.
	Interoperable	Ensure the medical unit has capabilities that function in harmony across all joint force elements and exchange medical services among units and commands at all levels.
	Complete	Medical requirements are integrated into the overall plan for mass casualty operations as a part of conflict or area damage control missions to return the injured and sick to duty or clear the operating area of those who cannot return to duty.
	Expeditionary	Organized, postured, and capable of rapid deployment, employment, and sustainment in an operating theater.
	Total Asset Visibility (TAV)	The ability to know the location, functionality, and availability of all required resources for reintegration of isolated personnel for evacuation or return to duty.
Provide health care	Deployable	Structured for rapid transport of modules to the field environment and readied to function fully within 30 days.
	Appropriate	Sufficiently meets assigned mission requirements 85% of the time.
	Acceptable	Satisfies the mission requirement 95% of the time.
	Complete	99.5% of care capability is planned for.
	Expeditionary	Modular components can be assembled to meet mission requirements 99.5% of the time.
	Flexible	Able to adapt or modify providing health care to meet changing operating environment and workloads.

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Operational Tasks	Conditions/Attributes	Standards
	Interoperable	Composed of multiple systems, capabilities, and organizations that are working in harmony across all joint force medical elements. Able to exchange knowledge and services among units and commands at all levels.
	Networked	Able to share a COP and be linked and synchronized electronically in order to increase operational effectiveness external consultations.
	Standardized	Conforming to established criteria of size, weight, quality, and functionality to permit substitution of modules without loss of facility function.
Supply operational dental care	Acceptable	Provide routine care in 95% of the cases.
	Flexible	Able to adapt to 90% of the operating environments to meet changing dental requirements.
	Effective	Treat combat casualties/non-combat injuries 100% of time.
	Complete	The dental system is 95% intact with all needed parts and elements.
Prepare for transport	Integrated	Composed of elements of medical care that function together in a coordinated fashion to achieve unity of effort for continuum of care in 90% of the cases.
	Flexible	Able to change time and mode of transport in order to effectively meet changing conditions or requirements 90% of the time.
	Networked	Transport systems and processes are linked and synchronized electronically 99% of the time.
	Appropriate	Sufficiently meets the mission requirements 90% of the time.
	Effective	Produces desired outcome 99% of the time.
	Interoperable	All elements of like DoD systems provide services to/accept services from other systems 99% of the time.
	Timely	Provided services to stabilize the patient, provide information, and knowledge on transport platforms, equipment, and medical staff in 95% of the cases.

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Operational Tasks	Conditions/Attributes	Standards
	Effective	Able to produce the intended results for successful transport in 99.5% of the cases.
	Practical	Staff is able to use common sense, judgment, and reason to find a direct and efficient path for patient transport.
	Reliable	Able to prepare 95% of patients for transport for an extended time under specified theater operating conditions without loss of critical function.
Provide interagency coordination	Adaptable	Able to change or adjust to different circumstances or conditions per agreements.
	Appropriate	Use coordination agreements that are suitable in 90% of situations to meet the intent of the medical mission.
	Comprehensive	When integrating with other agencies and nations, ensure coordination efforts are inclusive of all relevant factors, issues, and capabilities.
	Decentralized	Lower echelon medical units are empowered to function quickly and independently in order to initiate coordination with agencies and nations to take advantage of short duration opportunities to meet mission accomplishment.
	Effective	Ensure joint medical communications architecture is established.
	Flexible	Able to modify agreements to effectively meet changing conditions or requirements.
	Integrated	Ensure agreements are composed of elements or parts that function together in a coordinated fashion to achieve unity of the medical effort.
	Interoperable	Ensure that all deployable medical systems supporting joint operations are interoperable between Service components.
	Synchronized	Ensure adequate standardization and interoperability policies are in place.
	Total Asset Visibility	Know all the locations, functionality, and availability of all required medical and support resources, whether human, equipment, supplies, or systems.
Provide En-route medical care capability	Synchronized	Coordinate the en-route medical care and prepare the patient for movement through multiple echelons of medical care at the proper time.

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Operational Tasks	Conditions/Attributes	Standards
	Standardized	Conforming to established criteria of staff training, education, and competency to ensure correct preparation of patient, vehicle and equipment to meet the evac mission.
	Responsive	Able to react to requests with timeliness appropriate to preparing for medical evacuation.
	Scalable	Planning en-route care requires the ability to be modified in magnitude according to the needs of the patient(s).
	Appropriate	Planning for suitable en-route care.
	Comprehensive	Inclusive of all relevant factors, issues, and capabilities when planning for en-route care through the echelons.
	Deployable	Medical unit with the capability to hold patients for up to 72 hours is structured to be transported to the field environment and rapidly readied for function in accomplishing its mission.
	Effective	Able to produce the intended en-route patient care 100% of the time.
	Expeditionary	Units providing en-route patient care are organized, postured, and capable of rapid deployment, employment, and sustainment.
	Interchangeable	Capable of substitution with the joint health service support system without the loss of function and effectiveness in 95% of the cases.
	Networked	Share a COP and be linked and synchronized electronically in order to increase operational effectiveness through coordinated movement and action on different evacuation vehicles and echelons of medical care.
	Reliable	Able to prepare for en-route care and use organic resources for an extended time in a theater operation under specified operating conditions without the loss of critical function or capability.
	Interoperable	All elements of like DoD systems provide en-route medical care services that are composed of systems and capabilities that are functional in harmony across all joint force elements.

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Operational Tasks	Conditions/Attributes	Standards
Coordinate with higher echelons of care	Networked	Systems and processes are able to be shared and linked using a COP and synchronized electronically in order to increase operational effectiveness through coordinated PM and action with higher echelons of care.
	Synchronized	Function in a coordinated fashion with specific actions across multiple agents occurring at the proper time and in the proper sequence to provide en-route care.
	Total Asset Visibility (TAV)	The ability to know the location, functionality, and availability of all required resources.
Support medical civil-military operations	Responsiveness	React to requests with timeliness appropriate to the situation needing defense medical support.
	Scalable	Operation planning and execution is designed to be capable of being modified in magnitude according to the needs of civilian circumstances.
	Synchronized	Functions in a coordinated fashion with specific responsibilities assigned that crosses multiple organizations that occur at the proper time and in the proper sequence.
	Tailorable	Modify or adjust care provided to the joint force, multinational government organizations, and civilian population to better meet the needs or demands of the circumstances.
	Shared	Coordinate disaster relief and/or humanitarian assistance in resources to support civil affairs forces.
	Adaptable	Able to change or adjust to different circumstances or conditions to foster liaison and functional working relationships with multiple organizations.
	Networked	Informs the Combatant Commander about the status of and assistance required by and provided to the civilian population. Provide a shared COP and be linked and synchronized electronically to increase operational effectiveness through coordinated movement and action.
	Relevant	Able to have a practical, germane, and substantial effect on the matter at hand to promote health maintenance and disease prevention.

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Operational Tasks	Conditions/Attributes	Standards
	Integrated	Composed of joint or coalition force and Host Nation, multinational governmental and nongovernmental civilian organizations and Authorities that function together in a coordinated fashion to achieve unity of effort.
Address legal issues	Relevant	Ensure the medical care and medical transport provided is effective in meeting nonmilitary populations and complies with appropriate host nation laws
	Effective	Accomplish medical obligations under international law to manage care in nonmilitary personnel such as HN civilians, third country nationals, detainees, and internally displaced persons as intended.
	Comprehensive	Implement recommendations on use of civilian health care infrastructure, medical resources and interagency health service support requirements, capabilities, and limitations within the bounds of international law.
	Complete	Understand whole entitlements, laws, and regulations for the provision of medical care to all DoD civilians, contractors, HN civilians, third country nationals, detainees, and internally displaced persons.
	Accurate	Ensure approved detainee medical care policies and international agreements for medical care are executed as intended.
	Timely	Deliver health care as needed for effectiveness as the situation develops.
	Responsive	Ability to relinquish military run medical operations back to civilian authorities according to international agreements.
<p>References:</p> <p>Joint Publication, JP 4-02, Health Services Support , 31 October 2006</p> <p>Department of the Army Field Manual, FM 8-10-15, Employment of the Field and General Hospitals – Tactics, Techniques, and Procedures, 26 March 1997</p> <p>Department of the Army Field Manual, FM 8-10-24, Area Support Medical Battalion – Tactics, Techniques, and Procedures, 13 October 1993</p> <p>Department of the Army Field Manual, FM 4-02.24, Area Support Medical Battalion – Tactics, Techniques, and Procedures, 28 August 2000</p>		

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FHP Capability 6.4

Casualty Management: Theater Hospitalization

DESCRIPTION OF CAPABILITY: The ability to provide capabilities that medical personnel require to repair, restore, stabilize, or rehabilitate casualties within the theater, including preparation for strategic transport, return to duty, or rehabilitation. The utilization of telemedicine in this setting is a force multiplier.

Table A39. Theater Hospitalization

Operational Tasks	Conditions/Attributes	Standards
Restore to health	Complete	Includes 95% of domains (all-encompassing system of health care required for restoration and rehabilitation).
	Interoperable	All elements of like DoD systems provide services to / accept services from other systems 99% of time.
	Tailorable	Joint force is able to rapidly compose as appropriate force and scale it to fit mission 95% of time.
Communicate	Complete	99% of applicable data/information is complete.
	Networked	Systems and processes link and synchronize capabilities 99% of time.
	Secure	Information assurance and free from data corruption while denying access to unauthorized person 99% of the time.
	Total Asset Visibility (TAV)	The ability to know the location, functionality, and availability of all required resources.
Prepare for transport	Appropriate	Sufficiently meets mission requirements 95% of the time.
	Effective	Produces desired outcome 99% of the time.
	Interoperable	All elements of like DoD systems provide services to / accept services from other systems 99% of time.
	Timely	Provide services, products, information, intelligence, and/or knowledge within a desired period 95% of the time.
Provide care	Effective	Produces desired outcome 99% of the time.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 6.5

Casualty Management: Medical Care in a CBRNE Environment

DESCRIPTION OF CAPABILITY: This capability includes preventive and reactive countermeasures to prevent contamination and CBRNE effects which delay, or compromise, safe casualty care.

- **Patient Decontamination** The ability to mitigate/counter identified contamination by ensuring sick, injured, wounded, or other persons are safe through the process of absorbing, destroying, neutralizing, making harmless, or removing chemical, biological agents or removing radioactive materials clinging to or around them. Patient decontamination may be required beyond gross decontamination by other agencies to ensure medical and/or dental care or treatment is not compromised; also includes the subsequent decontamination of MHS personnel and equipment which may become exposed and become ineffective for continued patient care.
- **Patient Medical Countermeasures** This capability includes preventive countermeasures such as chemically and biologically hardening and physical protection of medical facilities to prevent contamination and CBRNE effects which delay or compromise safe casualty care.

Table A40. Medical Care in a CBRNE Environment

Operational Tasks	Conditions/Attributes	Standards
Standardized bio-chemically hardened field medical facilities	Appropriate	Sufficiently meets mission requirements 95% of the time.
	Effective	Produces desired outcome 99% of the time.
	Interoperable	All elements of like DoD systems provide services to / accept services from other systems 99% of time.
Develop patient / staff decontamination assemblages	Appropriate	Sufficiently meets mission requirements 95% of the time.
	Effective	Produces desired outcome 99% of the time.
	Interoperable	All elements of like DoD systems provide services to / accept services from other systems 99% of time.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 7.1

Medical Command and Control: Plan Collaboratively

DESCRIPTION OF CAPABILITY: This capability involves an effects-based approach that directly ties offensive actions to campaign objectives, drawing on global resources and considering global consequences. Planning must be conducted with the collective knowledge of the decisions and plans of others to produce coherent integration.

Table A41. Plan Collaboratively

Operational Tasks	Conditions/Attributes	Standards
Conduct joint health service support feasibility.	Accurate	The information presented correlates with the accuracy of the information provided 97% of the time.
	Timely	Feasibility study is conducted in time to support the task/mission at hand in 100% of the instances.
Collaboratively develop joint medical plans, orders and directives to include medical deployment and sustainment planning to support Joint Task Force (JTF) planning efforts.	Comprehensive	95% of the operational plans are integrated/synchronized/mutually supportive and result in the success of the campaign plan.
	Complete	99% of applicable data/information, etc. is complete.
	Interoperable	DoD C2 data & info is 95% interoperable.
	Practical	Ensures mission success with minimal complexity and friction, while maintaining 97% operational continuity and understanding in a significantly degraded environment.
	Timely	Operational plans are completed in time to conduct the task/mission in accordance with higher commander's intent. .
Collaboratively develops joint medical operations plans in order to develop Annex Q and other appropriate plans.	Comprehensive	95% of the operational plans are integrated/synchronized/mutually supportive and result in the success of the campaign plan.
	Complete	The aggregate of all the operational plans address all of the specified and implied tasks of the joint/coalition campaign/synchronization plan.
	Relevant	The operational plans meet the commander's intent/guidance.
	Responsive	Operational plans include branches and sequels necessary to address 80% of changing conditions. Frequency of operational plans changes/additions/amendments occur less than one per day.

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Operational Tasks	Conditions/Attributes	Standards
	Timely	Operational plans are completed in time to conduct the task/mission in accordance with higher commander's intent.
	Interoperable	DoD C2 data & info is 90% interoperable. -US interagency data & info is 90% interoperable. - 5-eye data & info is 75% interoperable. - Multinational data & info is 50% interoperable.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 7.2

Medical Command and Control: Leverage Mission Partners

DESCRIPTION OF CAPABILITY: Medical leaders must be able to achieve/maintain unity of effort and to leverage the capabilities of mission partners across varied command lines and organizational structures. Mission partners may include other DoD units, non-DoD agencies, state, federal, tribal, coalition forces and non-government and international organizations. This capability reflects the ability to coordinate, collaborate, influence, persuade, negotiate and diplomatically achieve synchronization of efforts according to shared information and plans.

Table A42. Leverage Mission Partners

Operational Tasks	Conditions/Attributes	Standards
Coordinate joint health service support operations with mission partners to ensure understanding of critical medical issues (e.g., blood, casualty management, casualty movement, etc.)	Comprehensive	85% of the mission partners' activities are mutually supportive and result in the success of the campaign plan.
	Reliable	85% of partners' activities meet or exceed expectations and are favorable to the commander's mission.
	Complete	The aggregate of the mission partners' activities support the specified and implied tasks of the joint/coalition campaign/synchronization plan.
Reference: Department of Defense Joint Force Health Protection Initial Capabilities Document (ICD), 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 7.3

Medical Command and Control: Establish/Adapt Lines of Communication and Relationships to Enable Global/Regional Collaboration of all Medical Partners

DESCRIPTION OF CAPABILITY: Medical leaders must be able to quickly establish or adapt command structures across the force and within the staff tailored to the mission, and to create the processes that will enable horizontal and vertical collaboration.

Table A43. Establish/Adapt Lines of Communication and Relationships to Enable Global/Regional Collaboration of all Medical Partners

Operational Tasks	Conditions/Attributes	Standards
Organize/develop a staff that aligns with the conditions of the mission environment, has assigned roles, and established internal structures to manage joint health service operations.	Interoperable	95% of data, processes, forces/equipment, systems are interoperable.
	Agile	Able to modify capabilities to meet changing mission requirements within time allowed 99% of the time.
	Practical	Ensures mission success with minimal complexity and friction, while maintaining 97% operational continuity and understanding in a significantly degraded environment.
Define/establish a joint health service support organizational structure to enable appropriate coordination relationships, including lines of authority and accountability between all applicable medical organizations (DoD, VA, HHS, civilian, etc.).	Comprehensive	Each organization is fully informed of the overall mission and its unique contribution to the missions (Information sharing: available and accessible).
	Agile	Adapt to changing demands and requirements within an appropriate timeframe.
	Practical	Ensures mission success with minimal complexity and friction, while maintaining 97% operational continuity and understanding in a significantly degraded environment.
	Responsive	Organizations able to rapidly adapt to changing conditions in terms of casualty management and casualty movement.
	Interoperable	Medical C2 data & info is 95% interoperable.
Establish/refine joint health service support C2 relationships to enable appropriate coordination, including lines of authority and accountability.	Interoperable	DoD users can access and use resources across all partners 90% of the time.
	Practical	Ensures mission success with minimal complexity and friction, while maintaining 97% operational continuity and understanding in a

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Operational Tasks	Conditions/Attributes	Standards
		significantly degraded environment.
	Reliable	95% of mission partners coordinated contributions meet or exceed expectations and are favorable to the commander's mission.
	Comprehensive	Mission partner products match or meet JTF medical mission goals to further the commander's intent. (e.g., use Sync matrix to measure).
Establish/refine relationships of the command with appropriate HN and CONUS local government organizations, local medical facilities and personnel, appropriate NGOs/IGOs, public health officials, etc.	Reliable	75% of mission partners coordinated contributions meet or exceed expectations and are favorable to the medical mission.
	Comprehensive	Mission partner products match or meet Combined JTF mission goals to further the commander's intent. (e.g., use Sync matrix to measure).
	Interoperable	Multinational, NGO/IGO data & info is 75% interoperable.
	Practical	Ensures effective medical care with minimal complexity and friction, while maintaining 97% operational continuity and understanding in a significantly degraded environment.
Identify collaboration requirements between medical forces in all operating environments and supporting all aspects of joint health service support; establish the collaboration infrastructure requirements.	Interoperable	Applicable collaboration environment is 95% interoperable.
	Accessible	95% bidirectional access to information on a standard medical collaboration tool.
	Complete	Collaboration tools have 95% of required information to effectively collaborate on medical operations.
Establish collaboration mechanisms (business rules, systems interface, etc.) with mission partners throughout the continuum of care, to include medical forces and facilities in theater, supporting the theater and in CONUS (to include VA, civilian facility)	Responsive	Mission partners can reconfigure in response to dynamic mission requirements and return to a steady state condition after reconfiguration 90% of the time.
	Secure	No compromise of information that impairs current operational effectiveness. No compromise of classified or medical information.
	Interoperable	Applicable collaboration environment is 95% interoperable.
Establish and direct JMC2 capabilities at the national level, incorporating appropriate federal (Department of	Complete	System availability is maintained at 97% to support all medical and public health contingencies.
	Agile	Ability to react and adapt in near real time to changing medical situations

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Operational Tasks	Conditions/Attributes	Standards
Health and Human Services, VA), state, local, public and private medical organizations to support the joint health service support mission.		and conditions to achieve a steady state condition.
Establish/refine collaboration processes and organizations to ensure seamless care and treatment of casualties evacuated from the theater.	Responsive	Mission partners can reconfigure in response to dynamic mission requirements and return to a steady state condition after reconfiguration 90% of the time.
	Secure	No compromise of information that impairs current operational effectiveness. No compromise of classified or medical information.
	Interoperable	Applicable collaboration environment is 95% interoperable.
	Accurate	The integrated information contains correct information (conforms to truth) 97% of the time.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 7.4

Medical Command and Control: Exercise Medical Management of Seamless Interoperable Medical Operations

DESCRIPTION OF CAPABILITY: This is the ability to collaboratively manage all medical assets and synchronize processes and standards in spite of varied command and control structures to ensure the expeditionary medical system seamlessly accomplishes its mission. This includes effective information management tasks of an interdependent joint force to create unity of effort through shared policy and guidance oftentimes without common lines of authority; accountability must be preserved to achieve shared success benefiting the deployed force casualties as well as the mission commanders.

Table A44. Exercise Medical Management of Seamless Interoperable Medical Operations

Operational Tasks	Conditions/Attributes	Standards
Promote adherence of the medical forces to federal, state and local medical laws, regulations and policies when supporting Homeland Defense/Defense support of civil authorities (HD/DSCA) operations.	Timely	Medical forces will be provided guidance on applicable state and local medical restrictions in a timely manner 99% of the time.
Provide guidance addressing joint health service support to non-combatant categories falling outside the law of war through all phases of the operations.	Relevant	99% of information is applicable to a given system or event.
	Timely	Guidance addressing medical treatment of non-combatant categories falling outside the law of war is issued in time 97% of the time for units and personnel to receive all applicable training.
Provide policy and guidance regarding the treatment of non-combatants that are consistent with established policies and national/international law.	Relevant	99% of information is applicable to a given system or event.
	Timely	Guidance addressing medical treatment of non-combatant categories falling outside the law of war is issued in time 97% of the time for units and personnel to receive all applicable training.
Train the joint medical force on those aspects of the law of war, applicable laws, executive orders and accepted behavior norms that are consistent with the policy and required for their medical mission.	Effective	Personnel act in accordance with the law of war, applicable laws, executive orders and accepted behavioral norms 100% of the time. 100% of personnel received applicable training.
Establish and cultivate	Effective	Personnel act with understanding of

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Operational Tasks	Conditions/Attributes	Standards
relations with appropriate coalition and mission partners (MCO), OGAs (SSTR) and federal, private and public sector leads (HD/DSCA) for joint health service support issues.		cultural and organizational differences 97% of the time.
	Reliable	Mission partners' actions meet or exceed commander's expectation.
	Interoperable	DoD users can access and use resources across all partners 90% of the time. U.S. interagency data & info is 90% interoperable.
Manage dissemination of appropriate medical information to the public; align public information dissemination with strategic communication objectives of higher authority in accordance with applicable laws and policies (HIPAA).	Timely	The information is available in time to conduct the task/mission at hand 99% of the instances.
	Accurate	100% of released information is correct/factual/truthful as is known at the time.
	Comprehensive	Information released by Combined JTF Public Affairs Office is not in conflict with higher PA guidance.
	Secure	No compromise of information that impairs current operational effectiveness. No compromise of classified information. No violation of applicable laws and policies Health Insurance Portability and Accountability Act (HIPAA).
	Practical	Methodology used is suitable for evaluating whether strategic communications can meet mission requirements.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 7.5

Medical Command and Control: Synchronize Execution across All Domains

DESCRIPTION OF CAPABILITY: Medical leaders must be able to achieve synchronization when operations are not executed as planned. This can be done through centralized redirection, as in the past, or in a decentralized manner through self-synchronization of subordinate forces. Medical leaders must have the ability to employ whichever method of synchronization is appropriate to the situation. Self-synchronization requires subordinates to have a clear understanding of the medical plans, shared SA and operational trust, the ability to act without detailed direction coupled with timely communications to all partners.

Table A45. Synchronize Execution Across All Domains

Operational Tasks	Conditions/Attributes	Standards
Collaboratively coordinate Intra and Inter PM. When applicable, coordinate with Unified Cross Domain Management Office (UCDMO), and ensure compliance with HIPAA throughout the continuum of care.	Accessible	95% of mission partners are able to access information on PM on a standard collaboration tool. 95% of authorized mission partners have access to classified information on a standard collaboration tool.
	Interoperable	Applicable collaboration environment is 95% interoperable.
	Accurate	Patient identity, location and status conforms to truth, within acceptable error 99.5% of the time.
	Timely	Patient status and movement information is entered on a timely basis.
	Complete	Patient movement information is available to 95% of the organizations in the evacuation chain.
Synchronize joint health service support operations, to include support to non-traditional populations.	Agile	Self-synchronized forces can execute decentralized medical operations 99% of the time.
	Timely	Self-synchronization of medical operations occurs in time to conduct the task/mission in accordance with higher commander's intent.
	Reliable	97% of forces have trust in medical support operation.
	Responsive	Medical operations are responsive to changing battlefield conditions caused by tactical and operational events.
	Interoperable	Applicable organizations can access and use resources across all partners 95% of the time.
Coordinate joint health service support operations with non-DoD	Interoperable	95% of data, processes, forces/equipment, systems are interoperable

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Operational Tasks	Conditions/Attributes	Standards
national agencies, NGOs and international organizations.	Comprehensive	Capabilities are linked and synchronous with a focused effect and unified purpose 80% of the time.
	Complete	All components of FHP meet requirements in time and location 90% of the time.
	Secure	System process/procedures have enhanced security characteristics 90% of the time.
	Effective	95% of personnel receive necessary guidance and act in accordance with that guidance 90% of the time.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 7.6

Medical Command and Control: Monitor Execution, Assess Effects and Adapt Operations

DESCRIPTION OF CAPABILITY: This capability involves the ability to maintain SA, assess plan execution effectiveness, and rapidly update plans by identifying alternative COAs and redirect forces as circumstances change. This is closely dependent upon maintaining visibility over friendly unit decisions and capabilities, and the ability to monitor and react to changes in adversary status. The ability to respond rapidly and effectively to changing circumstances will drive greater demands to share and synchronize to maintain the initiative and retain a seamless unity of effort.

Table A46. Monitor Execution, Assess Effects and Adapt Operations

Operational Tasks	Conditions/Attributes	Standards
Monitor execution of joint health service support operations using the JOA COP	Complete	95% of domains included.
	Timely	Outcomes meet time specific requirements 99% of the time.
	Comprehensive	Medical mission maintains designed functionality 99% of the time.
Track and monitor the location and condition of patients being transported throughout the continuum of care.	Complete	All available medical information is considered in conducting casualty management.
	Accurate	Patient identity, location, and status conforms to truth, within acceptable error 99.5% of the time.
	Practical	Assessment methodology used is suitable for evaluating whether the planned effects achieve the commander's objectives and intent.
	Agile	Medical organizations can accommodate multiple phases and effectively respond to changes in casualty management dynamics without detracting from the primary mission. Medical community can reconfigure assets for a changing environment.
Collaboratively assess effectiveness of joint health service support operations in theater.	Accurate	Assessed effects conform to truth within acceptable error.
	Timely	Continuous assessments of medical operations are completed in time to effectively monitor/adapt medical operations.
Continuously analyze and adapt joint health service support plans to changing operational situations	Flexible	Plans and execution orders are adaptable 99% of the time.
	Complete	Ability to execute simultaneous courses of action 99% of the time.
	Agile	Decisions/actions meet changing requirements 99% of the time.
Manage operational	Flexible	Plans and execution orders are

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Operational Tasks	Conditions/Attributes	Standards
transitions through all phases of the operation.		adaptable 99% of the time.
	Complete	Ability to execute simultaneous courses of action 95% of the time.
	Agile	Decisions/actions meet changing requirements 99% of the time.
	Effective	100% of personnel receive updated guidance on changes to the health service support mission and act in accordance with that guidance 97% of the time.
Facilitate joint health service support mission handoff	Flexible	Plans and execution orders are adaptable 99% of the time.
	Practical	99% of services maintained.
	Agile	Decisions/actions meet changing requirements 99% of the time.
	Effective	100% of personnel receive updated guidance on changes to the health service support mission and act in accordance with that guidance 97% of the time.
Reference: Department of Defense Joint Force Health Protection Initial Capabilities Document (ICD), 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 8.1

Shared Situational Understanding and Awareness: Communicate Medical Plan to Support Commander's Intent and Guidance

DESCRIPTION OF CAPABILITY: The shared Medical Plan must address the commander's intent in a concise expression of the operational purpose and desired end state. The medical plan must adapt to changes in the commander's intent and must be shared early and often to enable parallel planning and self-synchronized execution of a seamless expeditionary medical system.

Table A47. Communicate Medical Plan to Support Commander's Intent and Guidance

Operational Tasks	Conditions/Attributes	Standards
Collaboratively conduct joint health service support mission analysis and communicate the medical plan in support of the JTF and medical components	Effective	Applicable Information/situation is understood 99% of the time.
	Accurate	Mission analysis is 99% error free.
	Complete	Addresses all of the specified and implied tasks within the commander's guidance.
	Shared	Ensures mission success with minimal complexity and friction, while maintaining 97% operational continuity and understanding in a significantly degraded environment.
	Timely	Health service support input is provided in time to conduct the task/mission at hand 100% of the instances.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 8.2

Shared Situational Understanding and Awareness: Develop and Maintain Shared Situational Awareness and Understanding

DESCRIPTION OF CAPABILITY: This capability includes the ability to access a COP presenting current and forecast information on adversary and friendly forces, neutral elements, the environment and geospatial information. The COP is built through access to both processed and raw data from sensors, analysts and other sources, and through collaborative analysis and assessment of this data. SA, transformed into knowledge through synthesis, experience and collaboration, enables situational understanding and a shared adaptive medical system.

Table A48. Develop and Maintain Shared SA and Understanding

Operational Tasks	Conditions/Attributes	Standards
Integrate joint medical and all source intelligence to assess environmental and enemy situation and forecast outcomes	Accurate	99% of information is correct/factual/truthful.
	Relevant	99% of information is applicable to a given event/situation.
	Complete	99% of applicable data/information, etc. is complete.
Integrate comprehensive medical information with joint force SA systems and processes	Accurate	99% of information is correct/factual/truthful.
	Timely	outcomes meet time specific requirements 99% of the time.
	Complete	99% of applicable data/information, etc. is complete.
Employ and capture COP to support the joint health service support mission; provide access and integrate information on location, identity, status (to include medical condition); collaboratively assess and share implications on joint health service	Accurate	Blue forces information conforms to truth, within the acceptable error required by the operational to tactical Warfighter (Blue Force SA criteria).
	Timely	The mission and mission capability information is available in time to conduct the task/mission at hand in 95% of the instances.
	Comprehensive	Near-full operational capability in a degraded environment due to great strength, durability, survivability, interdependency, resiliency, a distributed nature, or a combination thereof, 97% of the time.
	Accessible	The user-defined operational picture (UDOP) must provide access to all COP data 97% of the time.
	Secure	No compromise of information that impairs current operational effectiveness. No compromise of classified information.
	Complete	Mission and mission capability information is available on 95% of the

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Operational Tasks	Conditions/Attributes	Standards
		forces.
Post appropriate medical information to the global information grid (GIG) for COIs	Interoperable	systems and processes link and synchronize capabilities 99% of the time.
	Relevant	Information is correctly targeted to correct person 90% of the time.
	Accessible	Information is available 80% of the time for COIs.
Determine and understand the joint health service support environment and medical status of coalition and mission partners and other populations in the JOA.	Relevant	90% of all information is applicable to a given situation or event.
	Timely	Information is provided in time to conduct the task/mission at hand in 85% of the instances.
	Accurate	The information provided conforms to fact or truth 90% of the time.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs)		

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FHP Capability 9.0

Support to Stability Operations

DESCRIPTION OF CAPABILITY: The ability to provide complementary health capabilities to achieve CCDR Stability Operations theater engagement objectives.

Table A49. Support to Stability Operations

Operational Tasks	Conditions/Attributes	Standards
International health and cultural preparedness training and education (TE)	Relevant	Medical Planners and Clinicians are prepared to advise and assist Host Nations.
	Effective	100% of personnel receive updated guidance on changes to the health service support mission and act in accordance with that guidance 97% of the time.
Provide care to host nation and other foreign populations in humanitarian assistance and disaster relief role	Flexible	Adaptive Force Packaging redefines, develops and/or modifies most FHP (Expeditionary Medical) Capabilities and platforms to respond to this different application.
	Complete	All Casualty Care capabilities (specialties) are available to care for a wide range of populations.
	Tailorable	Assemblages of equipment and personnel (UTCs) are developed to tailor to needs of the mission (First Responder – Primary Care, Fwd Resuscitative Care – Emergency Surgery, and Specialties such as OB/GYN, Pediatrics, Geriatrics, and Dental).
Apply FHP capabilities in this different environment of training and development of health care systems	Tailorable	Assemblages of equipment and personnel (unit type code (UTC)) are developed to tailor to needs of the mission (such as Casualty Care training, Preventive Medicine/Public Health, Medical Sustainment (supplies, equipment, and bio-med maintenance).
	Relevant	Medical Planners and Clinicians are prepared to advise and assist Host Nations.
Reference: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs); Health Readiness CONOPS Working Group and Subject Matter Experts		

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FHP Capability 10.0

Support to Homeland Defense and Civil Support (HD/CS) Operations

DESCRIPTION OF CAPABILITY: The ability to provide reinforcing health support to the homeland if the nation were to endure a natural or technological catastrophic event.

Table A50. Support to Homeland Defense and Civil Support (HD/CS) Operations

Operational Tasks	Conditions/Attributes	Standards
Provide care to affected and outlying populations in humanitarian assistance and disaster relief role	Flexible	Adaptive Force Packaging redefines, develops and/or modifies most FHP (Expeditionary Medical) Capabilities and platforms to respond to this different application.
	Complete	All Casualty Care capabilities (specialties) are available to care for wide range of populations.
	Tailorable	Assemblages of equipment and personnel (UTCs) are developed to tailor to needs of the mission (First Responder – Primary Care, Fwd Resuscitative Care – Emergency Surgery, and Specialties such as OB/GYN, Pediatrics, Geriatrics, and Dental).
Medical leadership, planners and providers of FHP capabilities and services provide assistance to other federal and state agencies	Interoperable	Medical Leaders, Planners and Clinicians are prepared to advise and assist areas/regions/states and territories seeking DoD medical assistance.
	Relevant	Medical Planners and Clinicians are prepared to advise and assist requesting agencies.
	Effective	Understanding - 100% of personnel receive updated guidance on changes to the health service support mission and act in accordance with that guidance 97% of the time.
Comply to Federal Emergency Management Agency emergency Support Function #8: Medical Tasks Federal Response Framework	Flexible	Plans and execution orders are adaptable 99% of the time.
	Complete	Ability to execute simultaneous courses of action 95% of the time.
	Agile	Decisions/actions meet changing requirements 99% of the time.
References: Department of Defense Instruction (DoDI) 2310.08E, Medical Program Support for Detainee Operations, 06 June 2006 Health Readiness CONOPS Working Group and Subject Matter Experts		

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FHP Capability 11.1

Detainee Medical Care: Detainee Healthcare

DESCRIPTION OF CAPABILITY: The ability to provide healthcare and safeguard the health of detained personnel in compliance with the provisions of the Geneva Convention and our nation's stance on human rights.

Table A51. Detainee Healthcare

Operational Tasks	Conditions/Attributes	Standards
Routine detainee healthcare	Timely	Provide routine detainee medical care within a desired period 95% of the time.
	Appropriate	Sufficiently meets detainee medical requirements 85% of the time.
	Effective	Produces desired outcomes 99% of the time.
	Accessible	Detainees access to routine sick call 100% of the time.
	Complete	Document detainee healthcare treatment is documented either electronically or in a written record 100% of the time.
Liaison with security	Timely	Meets with security on a routine basis 100% of the time to coordinate detainee security during medical treatment.
	Effective	Produces desired outcomes 99% of the time.
Report suspected detainee abuse	Timely	Reports suspected detainee abuse within 24 hours of identification 100% of the time.
	Accurate	Accurately records suspected detainee abuse injuries 100% of the time.
Rule on legal issues	Relevant	Wounded and sick detainees or other personnel in US custody may be treated in MTFs.
Diagnosis	Accurate	Diagnosis is correct 99% of the time.
	Timely	Diagnosis is delivered to the detainee 95% of the time.
	Accessible	Detainees access to routine sick call 100% of the time.
Restore to health	Effective	Produces desired outcome 99% of the time.
	Timely	Provide services, products, information, etc. within desired period 95% of the time.

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Operational Tasks	Conditions/Attributes	Standards
Document detainee healthcare	Complete	Detainee healthcare treatment is recorded 100% of the time.
	Timely	Document detainee healthcare treatment within 24 hours of healthcare visit 99% of the time.
<p>References:</p> <p>Clinical Best Practice Initiatives (DBPI), CPGs</p> <p>Department of Defense Directive (DoDD) 2310.01E, The Department of Defense Detainee Program, September 5, 2006</p> <p>Department of Defense Instruction (DoDI) 6025.8, Ambulatory Procedure Visit, 23 September 1996</p> <p>Department of Defense Instruction (DoDI) 2310.08E, Medical Program Support for Detainee Operations, 06 June 2006</p> <p>ASD(HA) Memorandum "Training for Health Care Providers in Detainee Operations,"</p> <p>ASD(HA) Memorandum 05-019,</p> <p>ASD(HA) Memorandum 02-005,</p> <p>Geneva Conventions, Article 3, Treatment of the Prisoners of War</p> <p>United States Code (USC), Title 42, Chapter 21D, Detainee Treatment</p> <p>Code of Federal Regulations (CFR), Title 28, Part 549, Medical Services</p>		

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FHP Capability 11.2

Detainee Medical Care: Detainee Emergency Healthcare

DESCRIPTION OF CAPABILITY: The ability to provide emergency medical care and safeguard the health of detained personnel in compliance with the provisions of the Geneva Convention and our nation's stance on human rights.

Table A52. Emergency Detainee Healthcare

Operational Tasks	Conditions/Attributes	Standards
First responder	Effective	Produces desired medical outcome 99% of the time.
	Appropriate	Sufficiently meets emergency situation requirements 85% of the time.
	Standardized	Training standards met by 95% of medical providers and 85% of non-medical first responders.
	Timely	Provided as soon as possible 99% of the time.
	Appropriate	Sufficiently meets mission requirements 85% of the time.
	Effective	Produces desired outcome 99% of the time.
	Timely	Provide services desired 95% of the time.
Resuscitative care	Effective	Produces desired outcome 99% of the time.
	Timely	Provide services desired 95% of the time.
	Accessible	Emergency resuscitative care equipment and properly trained personnel are available to detainees 100% of the time.
	Appropriate	Sufficiently meets mission requirements 85% of the time.
	Effective	Produces desired outcome 99% of the time.
	Timely	Provide services desired 95% of the time.
	Integrated	All capabilities are linked & synchronous with focused effort 99% of the time.
	Tailorable	Rapidly compose & scale treatment to fit the detainee 85% of the time.

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Operational Tasks	Conditions/Attributes	Standards
Document healthcare	Complete	Detainee healthcare treatment is recorded 100% of the time.
	Timely	Document detainee healthcare treatment within 24 hours of dental visit 99% of the time.
<p>References:</p> <p>Clinical Best Practice Initiatives (DBPI), CPGs</p> <p>Department of Defense Directive (DoDD) 2310.01E, The Department of Defense Detainee Program, September 5, 2006</p> <p>Department of Defense Instruction (DoDI) 6025.8, Ambulatory Procedure Visit, 23 September 1996</p> <p>Department of Defense Instruction (DoDI) 2310.08E, Medical Program Support for Detainee Operations, 06 June 2006</p> <p>ASD(HA) Memorandum "Training for Health Care Providers in Detainee Operations,"</p> <p>ASD(HA) Memorandum 05-019,</p> <p>ASD(HA) Memorandum 02-005,</p> <p>Geneva Conventions, Article 3, Treatment of the Prisoners of War</p> <p>United States Code (USC), Title 42, Chapter 21D, Detainee Treatment</p> <p>Code of Federal Regulations (CFR), Title 28, Part 549, Medical Services</p>		

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FHP Capability 11.3

Detainee Medical Care: Dental Care

DESCRIPTION OF CAPABILITY: The ability to ensure that detainee dental care is conducted in compliance with the provisions of the Geneva Convention and our nation's stance on human rights.

Table A53. Dental Care

Operational Tasks	Conditions/Attributes	Standards
Routine dental care	Accessible	Access to routine dental care 100% of the time.
	Effective	Sufficiently meets detainee dental requirements 85% of the time.
	Complete	Document detainee dental treatment either electronically or in a written record 100% of the time.
Emergency dental care	Accessible	Access to routine sick call 100% of the time.
	Effective	Sufficiently meets detainee dental requirements 85% of the time.
	Complete	Document detainee dental treatment 100% of the time.
Diagnosis	Accessible	Access to routine dental care 100% of the time.
	Effective	Sufficiently meets detainee dental requirements 85% of the time.
	Complete	Document detainee dental treatment either electronically or in a written record 100% of the time.
Restore to health	Accessible	Access to routine sick call 100% of the time.
	Effective	Sufficiently meets detainee dental requirements 85% of the time.
	Complete	Document detainee dental treatment 100% of the time.
Document detainee dental care	Accurate	Records accurately reflect detainee dental treatment 99% of the time.
	Timely	Records are documented within 24 hours of detainee dental visit 99% of the time.

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Operational Tasks	Conditions/Attributes	Standards
References: Clinical Best Practice Initiatives (DBPI), CPGs Department of Defense Directive (DoDD) 2310.01E, The Department of Defense Detainee Program, September 5, 2006 Department of Defense Instruction (DoDI) 6025.8, Ambulatory Procedure Visit, 23 September 1996 Department of Defense Instruction (DoDI) 2310.08E, Medical Program Support for Detainee Operations, 06 June 2006 ASD(HA) Memorandum "Training for Health Care Providers in Detainee Operations," ASD(HA) Memorandum 05-019, ASD(HA) Memorandum 02-005, Geneva Conventions, Article 3, Treatment of the Prisoners of War United States Code (USC), Title 42, Chapter 21D, Detainee Treatment Code of Federal Regulations (CFR), Title 28, Part 549, Medical Services Department of the Army Technical Bulletin, TB Med 250, Dental Record Administration, Recording, and Appointment Control, April 2006		

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FHP Capability 12.1

Operational Medical Logistic Support: Medical Logistics Integration

Description of Capability: The ability to synchronize and integrate the provision of medical logistics for HR support to the joint force in a designated operational area.

Table A54. Medical Logistics Integration

Operational Tasks	Conditions/Attributes	Standards
Respond to medical logistics demands based on clinically-driven needs	Reliable	Capability is appropriately tailored to meet 100% of mission requirements within commander's intent.
	Responsive	Maintains designed functionality 99% of the time.
	Effective	Meets mission requirements with no more than 10% of excess capacity across the medical supply chain or within the process.
Coordinate joint medical logistics needs with Host Nation support, Inter Governmental Organization, multi-national, prime vendor organization and Non-Governmental Organization	Complete	90% of applicable data/information, etc. is complete.
	Interoperable	All elements of the system are able to provide services to and accept services from other systems, units, or forces 99% of the time within DoD.
	Effective	Produces desired outcome 95% of the time.
Acquire all-source logistics information	Accessible	Available when needed to meet mission requirements 95% of the time.
	Accurate	99% error free.
	Reliable	Important or applicable 99% of the time.
	Interoperable	All elements of system provide services to and accept services from other systems, units, or forces 99% of time in DoD.
	Timely	Outcomes meet time-specific requirements 99% of the time.

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Operational Tasks	Conditions/Attributes	Standards
Predict clinical and logistical needs and capabilities to create a medical COP	Accessible	Available when needed to meet mission requirements 95% of the time.
	Accurate	99% error free.
	Reliable	Important or applicable 99% of the time.
	Interoperable	All elements of system provide services to and accept services from other systems, units, or forces 99% of time in DoD.
	Timely	Outcomes meet time-specific requirements 99% of the time.
Communicate clinical and logistical needs, capabilities, and status to create a medical COP	Accessible	Available when needed to meet mission requirements 95% of the time.
	Accurate	99% error free.
	Reliable	Important or applicable 99% of the time.
	Interoperable	All elements of system provide services to and accept services from other systems, units, or forces 99% of time in DoD.
	Timely	Outcomes meet time-specific requirements 99% of the time.
Develop courses of action (COA)	Complete	90% of applicable data/information, etc. is complete.
	Flexible	Able to meet 95% of missions changes with existing resources.
	Integrated	All elements of the system are able to provide services to and accept services from other systems, units, or forces 99% of the time within DoD.
Evaluate and select courses of action (COA)	Complete	90% of applicable data/information, etc. is complete.
	Effective	Produces desired outcome 95% of the time.
	Interoperable	Logically integrates all mission factors and joint capabilities 95% of the time.
Develop Medical Logistics Appendix to Annex Q	Complete	90% of applicable data/information, etc. is complete.
	Effective	Produces desired outcome 95% of the time.
	Interoperable	Product appropriately leverages the interdependencies of all partners 95% of the time.

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Operational Tasks	Conditions/Attributes	Standards
Update and adjust Medical Logistics Appendix to Annex Q based on changing situation	Flexible	Able to meet 95% of missions changes with existing resources.
	Interoperable	Outcomes meet time-specific requirements 99% of the time.
	Effective	Meets mission requirements with no more than 20% of excess capacity across the medical supply chain or within the process.

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FHP Capability 12.2

Operational Medical Logistic Support: Medical Logistics Management

Description of Capability. The ability to manage and maintain visibility of medical logistics for HR support to the joint force in a designated operational area.

Table A55. Medical Logistics Management

Operational Tasks	Conditions/Attributes	Standards
Measure and assess performance of medical logistics	Complete	95% of applicable data/information, etc. is complete.
	Reliable	Maintains designed functionality 99% of the time.
	Timely	Measurement outcomes meet time-specific requirements 99% of the time.
	Interoperable	Able to rapidly and efficiently share data, intelligence and knowledge to evaluate performance 95% of the time.
Take action to address performance deficiencies	Effective	Produces desired outcome 95% of the time.
	Flexible	Able to meet 95% of mission's changes with existing resources.
	Timely	Performance adjusted to meet requirements 99% of the time.
Manage the Class VIII-A materiel	Efficient	Meets mission requirements with no more than 20% of excess capacity across the medical supply chain or within the process.
	Predictive	Provides required materiel in the right quantity, place and condition 95% of the time.
	Reliable	Meets customer expectations 95% of the time.
	Timely	Outcomes meet time-specific requirements 99% of the time.
	Accurate	Provide the correct location, quantity, and condition of Class VIII materiel 98% of the time..
Provision and management of standardized medical equipment	Durable	Assess, standardize, procure and life cycle maintain all medical equipment 95% of the time.
Manage the Class VIII-B materiel throughout end-to-end supply chain	Effective	Meets mission requirements with no more than 20% of excess capacity across the medical supply chain or within the process.
	Predictive	Provides required materiel in the right quantity, place and condition 95% of the time.

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Operational Tasks	Conditions/Attributes	Standards
	Reliable	Meets customer expectations 95% of the time.
	Timely	Outcomes meet time-specific requirements 99% of the time.
	Accurate	Transport, track in real time (in-transit visibility), receive, store, and distribute blood supplies required to be maintained within set temperature parameters 100% of the time.
Coordinate the distribution of medical materiel in the JOA	Flexible	Able to meet 95% of missions changes with existing resources.
	Agile	Capability is appropriately sized to meet 100% of mission requirements within commander's intent.
	Effective	Provides required materiel and/or service in the right quantity, place and condition 95% of the time.
	Timely	Outcomes meet time-specific requirements 99% of the time.
Manage optical fabrication and repair	Flexible	Able to meet 95% of mission changes with existing resources.
	Interoperable	All elements of system provide services to and accept services from other systems, units, or forces 99% of time in DoD.
	Timely	Outcomes meet time-specific requirements 99% of the time.
	Reliable	Meets customer expectations 95% of the time.
Manage biomedical maintenance	Flexible	Able to meet 95% of mission changes with existing resources.
	Timely	Outcomes meet time-specific requirements 99% of the time.
	Interoperable	All elements of system (including info systems) provide services to and accept services from other systems, units, or forces 95% of time in DoD.
	Reliable	Meets customer expectations 95% of the time.
	Acceptable	Determine training, level of maintenance (organizational, intermediate, depot), required 95% of the time.
Manage medical facilities	Flexible	Able to meet 95% of mission changes with existing resources.
	Interoperable	All elements of system provide services to and accept services from other systems, units, or forces 95% of

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Operational Tasks	Conditions/Attributes	Standards
		time in DoD.
	Reliable	Meets customer expectations 95% of the time.
	Safe	Meets customer expectations within acceptable tolerances 99% of the time.
	Adaptable	Assess, standardize, procure and life cycle maintain medical facilities capable of maintaining required climate control (temperature, humidity, and air quality).
Provision of hazardous material including medical gasses	Deployable	Following safety guidelines and governing instructions, order, coordinate transportation, track, receive, store, and distribute required hazardous material 98% of the time.
Management of medical waste	Effective	Following safety guidelines and governing instructions, report, store, and dispose of medical waste 100%.
Technology	Accurate	Identify, validate, plan, resource, develop, test, produce or procure, and sustain standardized technology that meets validated requirements 98% of the time.
Health services contract management	Appropriate	Provide contract support for contract development, monitoring, modification and termination. 95% of the time.
References: Department of Defense <i>Joint Force Health Protection Initial Capabilities Document (ICD)</i> , 24 February 2010, Volume II, Functional Needs Analysis Reports (FNAs); Joint Pub 4-02 and Health Readiness CONOPS; Health System Support CONOPS; Joint Medical Logistics and Infrastructure Support Joint Capabilities Document (JMLIS JCD)		

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APPENDIX C: GLOSSARY

Part I. Acronyms

AE	aeromedical evacuation
AOR	area of responsibility
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
BA	battlespace awareness
BI	business intelligence
BRAC	Base Realignment and Closure
C2	command and control
CASEVAC	casualty evacuation
CASF	contingency aeromedical staging facility
CBA	Capabilities-Based Assessment
CBRNE	Chemical, Biological, Radiological, Nuclear, and High Yield Explosive
CCDR	Combatant Commander
CCJO	Capstone Concept for Joint Operations
CJCS	Chairman of the Joint Chiefs of Staff
CJCSI	Chairman of the Joint Chiefs of Staff Instruction
CJCSM	Chairman of the Joint Chiefs of Staff Manual
CMO	civil-military operations
COA	course of action
COCOM	Combatant Commander
COI	community of interest
CONOPS	Concept of Operations
CONUS	continental United States
COP	common operational picture
COSC	combat and operational stress control
COSR	combat and operational stress reactions
CS	civil support
DepSecDef	Deputy Secretary of Defense
DNBI	disease and non-battle injury
DoD	Department of Defense
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DOTMLPF	Doctrine, Organization, Training, Materiel, Leadership and Education, Personnel and Facilities
DSCA	defense support of civil authorities
EHR	electronic health record
FCB	Functional Capability Board
FDA	Food and Drug Administration

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FEMA	Federal Emergency Management Agency
FHP	Force Health Protection
FNA	functional needs analysis
FP	force protection
FS	force support
GIG	global information grid
HD	homeland defense
HD/CS	homeland defense/civil support
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HJO	healthcare in joint operations
HN	host nation
HNS	host nation support
HPO	Human Performance Optimization
HR	Health Readiness
HS	Homeland Security
HSD	Health Service Delivery
HSI	Human Systems Integration
HSS	Health System Support
IA	Information assurance
ICD	Initial Capabilities Document
IGO	international/agency government organization
IPT	integrated process team
JCA	joint capabilities area
JCIDS	Joint Capabilities Integration and Development System
JCM	joint casualty management
JFC	joint functional concept
JFHP	joint force health protection
JMLIS	joint medical logistics and infrastructure support
JOA	joint operations area
JOC	joint operating concepts
JOE	joint operational environment
JOpsC	joint operations concepts
JP	joint publication
JROC	Joint Requirements Oversight Council
JTF	joint task force
KM	knowledge management
KM/DS	Knowledge Management/Decision Support
MCMO	medical civil-military operations
MCO	major combat operations

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MEDEVAC	medical evacuation
MHS	military health system
MHS-OT	Military Health System Office of Transformation
MIPOE	medical intelligence preparation of the operational environment
MTF	medical treatment facility
NDAA	National Defense Authorization Act
NDS	national defense strategy
NGO	non-governmental organization
OEG	operational exposure guidance
OEH	occupational and environmental health
OEHS	occupational and environmental health surveillance
PBD	Program Budget Decision
PM	Patient movement
PMI	Patient movement item
PMR	Patient movement request
POM	Program Objective Memorandum
QDR	Quadrennial Defense Review
RT	real-time
SA	situational awareness
SAMMC	San Antonio Medical Center
SAR	search and rescue
SECDEF	Secretary of Defense
SME	subject matter expert
SMMAC	Senior Military Medical Advisory Council
SO	stability operations
SSTR	stability, security, transition, and reconstruction
SSTRO	stability, security, transition, reconstruction, and operations
TBI	traumatic brain injury
TIM	toxic industrial material
TRAC2ES	TRANSCOM regulating and command & control evacuation system
UDOP	user-defined operational picture
USG	United States Government
UTC	unit type code
VA	Department of Veterans Affairs
WG	working group
WMD	weapons of mass destruction

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Part II. Glossary

Aeromedical Evacuation. The movement of patients under medical supervision to and between MTFs by air transportation. Also called AE. (JP 1-02)

Aeromedical Evacuation System. A system which provides: a. control of PM by air transport; b. specialized medical aircrew, medical crew augmentees, and specialty medical attendants and equipment for in-flight medical care; c. facilities on or in the vicinity of air strips and air bases for the limited medical care of in transit patients entering, en-route via, or leaving the system; and d. communication with originating, destination, and en-route medical facilities concerning patient transportation. Also called AES. (JP 1-02)

Battlespace. The environment, factors, and conditions that must be understood to successfully apply combat power, protect the force, or complete the mission. This includes the air, land, sea, space, and the included enemy and friendly forces; facilities; weather; terrain; the electromagnetic spectrum; and the information environment within the operational areas and areas of interest. (JP 1-02, JP 3-35)

Battle Injury. Damage / harm sustained during/as result of battle conditions. Also called BI. (JP 4-02 and approved for next edition of JP 1-02.)

Board. An organized group of individuals within a Joint Force commander's headquarters, appointed by the commander (or other authority), that meets with the purpose of gaining guidance or decision. Its responsibilities and authority are governed by the authority that established the board. (JP 3-33)

Born Joint. This is a characteristic of deliberate interoperability in which capabilities are conceptualized and designed with joint architectures and acquisition strategies. This level of interoperability ensures technical, DOTMLPF, and cultural barriers do not limit the ability of Joint Commanders to achieve objectives. (derived from JOpsC, Nov 03)

Capability. The ability to execute a specified course of action. (A capability may or may not be accompanied by an intention.) (JP 1-02) It is defined by an operational user and expressed in broad operational terms in the format of an initial capabilities document or a DOTMLPF change recommendation. Also called capabilities. (Source: N/A)

Capstone Concept for Joint Operations (CCJO). The overarching concept of the joint operational concepts family of documents that guides the development of future joint capabilities. It applies to operations worldwide conducted unilaterally or in conjunction with multinational military partners and other government and non-government agencies. (Source: N/A)

Casualty. Any person who is lost to the organization by having been declared dead, duty status—whereabouts unknown, missing, ill, or injured. (JP 1-02) See also Casualty Category; Casualty Status; Casualty Type; Duty Status—Whereabouts Unknown; Hostile Casualty; Non-Hostile Casualty. (Source: N/A)

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Casualty Category. A term used to specifically classify a casualty for reporting purposes based upon the casualty type and the casualty status. Casualty categories include killed in action, died of wounds received in action, and wounded in action. (JP 1-02)

Casualty Evacuation. The unregulated movement of casualties that can include movement to and between MTFs. Also called CASEVAC. See also Casualty; Evacuation; Medical Treatment Facility. (JP 1-02)

Casualty Status. A term used to classify a casualty for reporting purposes. There are seven casualty statuses: (1) deceased; (2) duty status - whereabouts unknown; (3) missing; (4) very seriously ill or injured; (5) seriously ill or injured; (6) incapacitating illness or injury; and (7) not seriously injured. (JP 1-02)

Casualty Type. A term used to identify a casualty for reporting purposes as either a hostile casualty or a non-hostile casualty. (JP 1-02)

Cell. A subordinate organization formed around a specific process, capability, or activity within a designated larger organization of a Joint Force commander's headquarters. A cell is usually part of a functional and traditional staff structure. (JP 3-33)

Center. An enduring functional organization, with a supporting staff, designed to perform a joint function within a Joint Force commander's headquarters. (JP 3-33)

Chemical, Biological, Radiological, Nuclear, and High Yield Explosive Hazard. Those chemical, biological, radiological, nuclear, and high-yield explosive elements that pose or could pose a hazard to individuals. Chemical, biological, radiological, nuclear, and high-yield explosive hazards include those created from accidental releases, toxic industrial materials (especially air and water poisons), biological pathogens, radioactive matter, and high-yield explosives. Also included are any hazards resulting from the deliberate employment of weapons of mass destruction during military operations. (JP 3-07.2)

Chemoprophylaxis. The use of medications or drugs to prevent adverse health consequences of an anticipated CBRN hazard exposure. (Source: NA)

Combat and Operational Stress. The expected and predictable emotional, intellectual, physical, and/or behavioral reactions of Service members who have been exposed to stressful events in war or military operations other than war. Combat stress reactions vary in quality and severity as a function of operational conditions, such as intensity, duration, rules of engagement, leadership, effective communication, unit morale, unit cohesion, and perceived importance of the mission. (JP 4-02, approved for next edition of JP 1-02.)

Combat and Operational Stress Control. Programs developed and actions taken by military leadership to prevent, identify, and manage adverse combat and operational stress reactions in units; optimize mission performance; conserve fighting strength; prevent or minimize adverse effects of combat and operational stress on members' physical, psychological, intellectual and social health; and to return the unit or Service member to duty expeditiously. (JP 4-02 and approved for next edition of JP 1-02.)

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Combat and Operational Stress Reactions. The physical, emotional, cognitive, or behavioral reactions, adverse consequences, or psychological injuries of Service members who have been exposed to stressful or traumatic events in combat or military operations. COSRs vary in severity as a function of operational conditions, such as intensity, duration, frequency of combat exposure, rules of engagement, leadership, effective communication, unit morale, unit cohesion, and perceived importance of the mission. (Source: N/A)

Combatant Command. A unified or specified command with a broad continuing mission under a single commander established and so designated by the President, through the Secretary of Defense, and with the advice and assistance of the Chairman of the Joint Chiefs of Staff. Combatant commands typically have geographic or functional responsibilities. (JP 1-02)

Combatant Commander. A commander of one of the unified or specified combatant commands established by the President. Also called CCDR. (JP 1-02)

Combat Formations. Those forces whose primary missions are to participate in combat. Also called operating forces, combat forces. (Source: NA)

Combat Service Support. The essential capabilities, functions, activities, and tasks necessary to sustain all elements of operating forces in theater at all levels of war. Within the national and theater logistic systems, it includes but is not limited to the support rendered by Service forces in ensuring the aspects of supply, maintenance, transportation, health services, and other services required by aviation and ground combat troops to permit those units to accomplish their missions in combat. Combat service support encompasses those activities at all levels of war that produce sustainment to all operating forces on the battlefield. Also called CSS. (JP 4-0)

Combat Zone. 1. That area required by combat forces for the conduct of operations. 2. The territory forward of the Army rear area boundary. See also combat area; communications zone. (JP 1-02)

Command and Control. The exercise of authority and direction by a properly designated commander over assigned and attached forces in the accomplishment of the mission. Command and control functions are performed through an arrangement of personnel, equipment, communications, facilities, and procedures employed by a commander in planning, directing, coordinating, and controlling forces and operations in the accomplishment of the mission. Also called C2. (JP 1-02)

Common Operational Picture. A single identical display of relevant information shared by more than one command. A common operational picture facilitates collaborative planning and assists all echelons to achieve SA. Also called COP. (JP 3-0)

Communications Zone. Rear part of a theater of war or theater of operations (behind but contiguous to the combat zone) which contains the lines of communications, establishments for supply and evacuation, and other agencies required for the immediate support and maintenance of the field forces. Also called COMMZ. (JP 4-0)

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Compatibility. The ability of systems, equipment, devices, and materiel to operate in their intended operational environments without suffering unacceptable degradation or without causing unacceptable performance interactions or responses. It involves the application of sound system, equipment, device, and materiel design configurations that ensures interference free operation, and clear concepts that maximize operational effectiveness. (JP 1-02)

Concept. A notion or statement of an idea; an expression of how something might be done. See Joint Concept. (JFHP CONOPS)

Countermeasures. A form of military science that, by the employment of devices and/or techniques, has as its objective the impairment of the operational effectiveness of enemy activity. Includes all types of therapeutic, clinical, and non-medical interventions that negate effects of threats or reduces risks (regardless of source) by minimizing or eliminating detrimental effect on mission success. (JP 1-02)

Definitive Care. Care rendered to conclusively manage a patient's condition. It includes the full range of preventive, curative, convalescent, restorative, and rehabilitative medical care. This normally leads to rehabilitation, return to duty, or discharge from the service. (JP 4-02)

Effect. (1) The physical or behavioral state of a system that results from an action, a set of actions, or another effect. (2) The result, outcome, or consequence of an action. (3) A change to a condition, behavior, or degree of freedom. (JP 3-0)

En-route Care. Continuation of the provision of care during movement (evacuation) between the health service support capabilities in the continuum of care, without clinically compromising the patient's condition. (JP 4-02)

En-route Care Capability. The ability to provide uninterrupted medical care from the point of injury or initial illness until patients arrive at a medical facility or between capabilities in the continuum of essential care, without compromise to the patient's condition. See also En-route Care. (JP 4-02)

Essential Care. Medical treatment provided to manage the casualty throughout the range of care. This includes all care and treatment to either return to duty (within the theater evacuation policy) or begin initial treatment required for optimization of outcome, and/or stabilization to ensure the patient can tolerate evacuation (JP 4-02)

Evacuation. (1) Removal of a patient by any of a variety of transport means (air, ground, rail, or sea) from a theater of military operation, or between health service support capabilities, for the purpose of preventing further illness or injury, providing additional care, or providing disposition of patients from the military healthcare system. (2) The clearance of personnel, animals, or materiel from a given locality. (3) The controlled process of collecting, classifying, and shipping unserviceable or abandoned materiel, US or foreign, to appropriate reclamation, maintenance, technical intelligence, or disposal facilities. (4) The ordered or authorized departure of noncombatants from a specific area by the Department of State, DoD, or appropriate military commander. This refers to the movement from one area to another in the same or different countries. The evacuation is

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caused by unusual or emergency circumstances and applies equally to command or non-command sponsored family members. See also Evacuee; Noncombatant Evacuation Operations. (JP 4-02)

Expeditionary Force — An armed force organized to accomplish a specific objective in a foreign country. (JP 3-0)

First Responder. Primary healthcare providers whose responsibility is the provision of immediate clinical care and stabilization in preparation for evacuation to the next health service support capability in the continuum of care. In addition to treating injuries, they treat service members for common acute minor illnesses. (JP 4-02)

First Responder Capability. The healthcare capability that provides immediate clinical care and stabilization to the patient in preparation for evacuation to the next health service support capability in the continuum of care. It involves several tiers of first responders with training in field sanitation and preventive medicine; highly proficient medical teams and organic medical structures that support combat formations and operational units that provide treatment of battlefield trauma within the first few minutes after injury; and those organic preventive medicine units/teams and medical biological detection teams that provide prevention and protection support to the force from natural, environmental, occupational, operational, industrial, behavioral, and nuclear-biological-chemical warfare health threats. (JP 4-02)

Force Health Protection. Joint healthcare capabilities and measures to promote, improve, conserve and restore the mental and physical wellbeing of deployed forces. FHP includes preventive, protective, restorative and rehabilitative medical and dental care for injuries and illnesses from health hazards and threats within a Joint Operational Area (JOA). FHP activities sustain a healthy and fit force, and include all measures taken by commanders, supervisors, individual service members, as well as the Military Health System (MHS) to support all beneficiaries and ensure the success of joint Warfighters across the range of military operations. FHP activities are enabled by the integration of Health Service Delivery (HSD) and Health System Support (HSS) capabilities as applied to expeditionary task force operations. (See also HSD and HSS). Note this phrase is more closely aligned to the concepts in JP 4-02, which under its latest revision, is being re-named to variations of “Healthcare in Joint Operations” (JHO).

Foreign Humanitarian Assistance (Abroad). Programs conducted to relieve or reduce the results of natural or manmade disasters or other endemic conditions such as human pain, disease, hunger, or privation that might present a serious threat to life or that can result in great damage to or loss of property. Foreign humanitarian assistance (FHA) provided by US forces is limited in scope and duration. The foreign assistance provided is designed to supplement or complement the efforts of the host nation civil authorities or agencies that might have primary responsibility for providing FHA. FHA operations are those conducted outside the United States, its territories, and possessions. Also called FHA. See also Humanitarian Assistance. (JP 1-02)

Forward Resuscitative Care. Care provided as close to the point of injury as possible based on current operational requirements to attain stabilization and achieve the most

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efficient use of life, limb, and eyesight saving medical treatment. Forward resuscitative care typically provides essential care for stabilization to ensure that the patient can tolerate evacuation. Also called FRC. See also Essential Care (JP 4-02) (Normally provided by medical personnel and also includes efforts to relieve pain and administer Forward/Resuscitative Surgery [FRS] care capabilities.)

Forward Resuscitative Surgical (FRS) Care Capability. The ability to perform surgical procedures as close to the point of injury to attain clinical stability and achieve the most efficient use of life-and-limb saving surgical treatment. (Source: NA)

Global Patient Movement Requirements Center. A joint activity reporting directly to the Commander, US Transportation Command, the Department of Defense single manager for the strategic and continental United States (CONUS) regulation and movement of uniformed services and other authorized patients. The Global Patient Movement Requirements Center (GPMRC) provides medical regulating and AE scheduling for CONUS and inter-theater operations and provides support to the Theater Patient Movement Requirements Centers. The GPMRC coordinates with supporting resource providers to identify available assets and communicates transport to bed plans to the appropriate transportation agency for execution. Also called GPMRC. (JP 4-02 and approved for next edition of JP 1-02.)

Group. 1. A flexible administrative and tactical unit composed of either two or more battalions or two or more squadrons. The term also applies to combat support and combat service support units. 2. A number of ships and/or aircraft, normally a subdivision of a force, assigned for a specific purpose. 3. A long-standing functional organization that is formed to support a broad function within a Joint Force commander's headquarters. Also called GP. (JP 3-33)

Healthcare Provider. Any member of the Armed Forces, civilian employee of the DoD, or personal services contract employee under 10 United States Code (USC) 1091 authorized by the DoD to perform healthcare functions. The term excludes any contract provider who is not a personal services contract employee. Also called DoD healthcare provider. (JP 4-02)

Health Readiness. Health readiness (an overarching term, CONOPS and JCA) is described as the broad spectrum of joint medical and health service support capabilities which integrates DoD health care transformation into the full spectrum of services required from the Servicemember's accession to veteran and among members of the military family by focusing on four integrated MHS mission elements: 1) Casualty Care and Humanitarian Assistance; 2) Healthy, Fit and Protected Force; 3) Healthy and Resilient Individuals, Families, and Communities; and 4) Education, Training and Research. Concepts and detailed capabilities are further captured in three subordinate CONOPSs (see FHP, HSD and HSS).

Health Service Delivery. The ability to provide acute or long-term primary or specialty care capabilities to all eligible beneficiaries outside the theater in either the direct or purchased care system. (HR CONOPS)

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Health Service Support. *(Note: This phrase will be replaced with the new use of the term “Health System Support” and its acronym (HSS) as introduced in the HR CONOPS and used throughout this document. The Joint Publication 4-02, currently titled “Health Service Support”, uses a definition which is more aligned with the term “Health Readiness” as the more inclusive JCA which includes such activities not addressed.)* All services performed, provided, or arranged to promote, improve, conserve, or restore the mental or physical well-being of personnel. These services include, but are not limited to, the management of health services resources, such as manpower, monies, and facilities; preventive and curative health measures; evacuation of the wounded, injured, or sick; selection of the medically fit and disposition of the medically unfit; blood management; medical supply, equipment, and maintenance thereof; combat stress control; and medical, dental, veterinary, laboratory, optometric, nutrition therapy, and medical intelligence services. Also called HSS. (JP 4-02) As used in this document, see JFHP and FHP.

Health System Support. The ability to perform healthcare administrative and support related functions to sustain and continuously improve MHS mission effectiveness through focused development of people, technology, infrastructure, and joint organizational culture. (HR CONOPS)

Health Surveillance. The regular or repeated collection, analysis, and interpretation of health-related data and the dissemination of information to monitor the health of a population and to identify potential risks to health, thereby enabling timely interventions to prevent, treat, or control disease and injury. It includes OEHS and medical surveillance. (JP 4-02 and approved for next edition of JP 1-02.)

Health Threat. A composite of ongoing or potential enemy actions; adverse environmental, occupational, and geographic and meteorological conditions; endemic diseases; and employment of nuclear, biological, and chemical weapons (e.g., WMDs) that have the potential to affect short- or long-term health (e.g., psychological impact) of personnel. (JP 4-02)

High Yield Explosive. Any conventional weapon or device that is capable of a high order of destruction or disruption and/or of being used in such a manner as to kill or injure large numbers of people. Also called HYE. (JP 1-02)

Homeland Defense. The protection of United States sovereignty, territory, domestic population, and critical infrastructure against external threats and aggression or other threats as directed by the President. Also called HD. (JP 3-0)

Homeland Security. As defined in the National Strategy for Homeland Security, a concerted national effort to prevent terrorist attacks within the United States, reduce America’s vulnerability to terrorism, (major disasters, and other emergencies) and minimize the damage and recover from attacks (major disasters, and other emergencies) that do occur. The DoD contributes to homeland security through its military missions overseas, homeland defense, and support to civil authorities. Also called HS. (JP 3-26)

Hospital. A medical treatment facility capable of providing inpatient care. It is appropriately staffed and equipped to provide diagnostic and therapeutic services, as well

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as the necessary supporting services required to perform its assigned mission and functions. A hospital may, in addition, discharge the functions of a clinic. (JP 1-02)

Hostile Casualty. A person who is the victim of a terrorist activity or who becomes a casualty “in action.” “In action” characterizes the casualty as having been the direct result of hostile action, sustained in combat or relating thereto, or sustained going to or returning from a combat mission provided that the occurrence was directly related to hostile action. Included are persons killed or wounded mistakenly or accidentally by friendly fire directed at a hostile force or what is thought to be a hostile force. Not to be considered, however, as sustained in action and not to be interpreted as hostile casualties are injuries or death due to the elements, self-inflicted wounds, combat fatigue, and except in unusual cases, wounds or death inflicted by a friendly force while the individual is in an absent-without-leave, deserter, or dropped-from-rolls status, or is voluntarily absent from a place of duty. (JP 1-02)

Host-Nation Support. Civil and/or military assistance rendered by a nation to foreign forces within its territory during peacetime, crisis or emergencies, or war based upon agreements mutually concluded between nations. Also called HNS. (JP 1-02)

Humanitarian and Civic Assistance. Assistance to the local populace provided by predominantly US forces in conjunction with military operations and exercises. This assistance is specifically authorized by title 10, USC, section 401, and funded under separate authorities. Assistance provided under these provisions is limited to (1) medical, dental, and veterinary care provided in rural areas of a country; (2) construction of rudimentary surface transportation systems; (3) well drilling and construction of basic sanitation facilities; and (4) rudimentary construction and repair of public facilities. Assistance must fulfill unit training requirements that incidentally create humanitarian benefit to the local populace. Also called HCA. See also Foreign Humanitarian Assistance. (JP 3-05.1)

Humanitarian Assistance. Programs conducted to relieve or reduce the results of natural or manmade disasters or other endemic conditions (e.g., human pain, disease, hunger, or privation) that might present a serious threat to life or that could result in great damage to or loss of property. Humanitarian assistance provided by US forces is limited in scope and duration. The assistance provided is designed to supplement or complement the efforts of the host nation civil authorities or agencies that may have the primary responsibility for providing humanitarian assistance. Also called HA. (JP 3-57) Derived from Foreign Humanitarian Assistance (FHA) (JP 3-05.1) See also Humanitarian and Civic Assistance (JP 1-02, JP 3-07.6)

Humanitarian Relief. Material or logistical assistance provided for humanitarian purposes, typically in response to humanitarian crises. The primary objective of humanitarian relief operations is to save lives, alleviate suffering, and maintain human dignity. It therefore may be distinguished from development aid, which seeks to address the underlying socioeconomic factors that might have led to a crisis or emergency. (Source: N/A)

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Interchangeable. The ability of systems, units, or forces to replace like systems, units, or forces that possess common capabilities and like characteristics to fulfill relevant requirements without causing unacceptable performance degradations when exchanged. (JP 1-02, HR CONOPS)

Interdependent. A service's purposeful reliance on another service's capabilities to maximize complementary and reinforcing effects, while minimizing relative vulnerabilities to achieve mission requirements of the Joint Force Commander. (JP 1-02, HR CONOPS)

Interoperability. (1) The ability to operate in synergy in the execution of assigned tasks. (JP 1-02) (2) The ability of systems, units, or forces to provide data, information, materiel and services to, and accept the same from, other systems, units, or forces and use the data, information, materiel, and services so exchanged to enable them to operate together effectively. (Manual for Operation of the Joint Capabilities Integration and Development System, February 2009 (Updated 31 July 2009)) (3) The degree of interoperability should be defined when referring to specific cases. (JP 3-32)

Intertheater Evacuation. See intertheater PM. (IAW JP 4-02, approved for removal from next edition of JP 1-02.)

Intertheater Patient Movement — Moving patients between, into, and out of the different theaters of the geographic combatant commands and into the continental United States or another supporting theater. See also **en-route care; evacuation; intratheater patient movement; patient.** (JP 4-02)

In-Transit Visibility. The ability to track the identity, status, and location of DoD and non-unit cargo (excluding bulk petroleum, oils, and lubricants) and passengers; medical patients; and personal property from origin to consignee or destination across the range of military operations. Also called ITV. (JP 1-02)

Intratheater Patient Movement. Moving patients within the theater of a combatant command or in the Continental United States. (JP 4-02) See en-route care.

Joint. Connotes activities, operations, organization, etc., in which elements of two or more military departments participate. (JP 0-2)

Joint Concept. Links strategic guidance to the development and employment of future joint force capabilities and serve as "engines for transformation" that may ultimately lead to doctrine, organization, training, materiel, leadership and education, personnel and facilities (DOTMLPF) and policy changes (JP 1-02)

Joint Force. A general term applied to a force composed of significant elements, assigned or attached, of two or more military departments, operating under a single Joint Force Commander. See also joint force commander. (JP 1-02) (JP 3-0)

Joint (Force) Commander. A general term applied to a combatant commander, subunified commander, or joint task force (JTF) commander authorized to exercise combatant command (command authority) or operational control over a joint force. Also called JFC. (JP 1-02) Note: Concept documents also use JFC for the name of a series of

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Joint Functional Concept documents, as defined below. (Note: To avoid confusion, the term “joint commander” without the acronym is used throughout this document.)

Joint Force Health Protection. A general term used throughout this document to capture the broad spectrum of “joint” medical or health service support capabilities and takes on the broader scope than the term “force health protection” which excludes “restorative” measures and capabilities. It is the name given to the Transformation Initiative as a result of the DEPSECDEF Memorandum entitled, *Improving Joint Warfighting through Joint Force Health Protection Transformation*. It is used primarily in discussing operational level concepts, capabilities and issues while still including all measures taken by commanders, supervisors, individual Service members, and the MHS to ensure the success of joint Warfighters across the range of military activities and operations. See JFHP. See also force health protection. (Source: NA)

Joint Functional Concept. An articulation of how a future Joint Force Commander will integrate a set of related military tasks to attain capabilities required across the range of military operations. Although broadly described within the joint operations concepts, they derive specific context from the joint operating concepts and promote common attributes in sufficient detail to conduct experimentation and measure effectiveness. Also called JFC. Per CJCSI 3010.02B, a JFC is one of a series of concept documents that apply elements of the CCJO solution to describe how the joint force, 8 to 20 years into the future, will perform an enduring military function across a range of military operations. It identifies the operational-level capabilities required and the key attributes necessary to compare capability or solution alternatives. (Note: JFC also is the JP 1-02 acronym for Joint Force Commander; however, to avoid confusion with joint functional concepts documents referenced throughout this concept document, only the term “joint commander” is used.)

Killed In Action. A casualty category applicable to a hostile casualty, other than the victim of a terrorist activity, who is killed outright or who dies as a result of wounds or other injuries before reaching a medical treatment facility. Also called KIA. See also casualty category. (Source: N/A)

Knowledge Management. The handling, directing, governing, or controlling of natural knowledge processes (acquire/validate, produce, transfer/integrate knowledge) within an organization in order to achieve the goals and objectives of the organization. Also called KM. (Source: N/A)

Lesson Learned. A technique, procedure, or practical workaround that enabled a task to be accomplished to standard based on an identified deficiency or shortcoming. (Source: N/A)

Major Combat Operations. Large-scale operations conducted against a nation state(s) that possesses significant regional military capability and the will to employ that capability in opposition to or in a manner threatening to US national security. Also called MCO. (Source: N/A)

Mass Casualty. Any large number of casualties produced in a relatively short time period, usually as the result of a single incident such as a military aircraft accident,

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hurricane, flood, earthquake, or armed attack that exceeds local logistical support capabilities. See also Casualty. (JP 1-02)

Materiel. Equipment and supplies in military and commercial supply chain management. In a military context, materiel relates to the specific needs of a force to complete a specific mission. The term also is used often in a general sense (“men and materiel”) to describe the needs of a functioning army. (Source: N/A)

Medical Civil-Military Operations. All health-related activities in support of a Joint Force Commander that establish, enhance, maintain, or influence relations between the joint or multinational force and host nation, multinational governmental and nongovernmental civilian organizations and authorities, and the civilian populace to facilitate military operations, achieve US operational objectives, and positively impact the health sector. Also called MCMO. (JP 4-02)

Medical Intelligence Preparation of the Operational Environment. A systematic continuing process that analyzes information on medical and disease threats, enemy capabilities, terrain, weather, local medical infrastructure, potential humanitarian and refugee situations, transportation issues, and political, religious, and social issues for all types of operations. Medical intelligence preparation of the operational environment is a component of the health service support mission analysis process, and the resulting statistics are used as a basis for developing health service support estimates and plans. It includes defining the operational environment, describing the operational environment effects on health service support operations, evaluating the operational environmental threats, and determining courses of action to meet actual and potential threats. Also called MIPOE. Previously called Medical Intelligence Preparation of the Battlefield (MIPB). (JP 4-02)

Medical Regulating. Actions and coordination necessary to arrange for the movement of patients through different levels of care. This process matches patients with a medical treatment facility that has the necessary health service support capabilities, ensures that bed space is available and allocates appropriate en-route care resources (teams and PMI) to accompany patients. (JP 1-02)

Medical Surveillance. The ongoing, systematic collection, analysis, and interpretation of data derived from instances of medical care or medical evaluation, and the reporting of population-based information for characterizing and countering threats to a population’s health, well-being, and performance. (JP 4-02)

Medical Treatment Facility. A facility established for the purpose of furnishing medical and/or dental care to eligible individuals. Also called MTF. (JP 1-02)

Metrics. Measurable qualities used to assess force application capabilities. They should capture relative value to the warfighter of different capabilities and systems. Metrics are derived from attributes, and each attribute can be described by one or many metrics. Metrics will be developed on a case-by-case basis for capabilities-based assessments, or developed within an integrated architecture. (Source: N/A)

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Military Health System (MHS). The health system that supports the military mission by fostering, protecting, sustaining, and restoring health. It also provides the direction, resources, healthcare providers, and other means necessary for promoting the health of the beneficiary population. These include developing and promoting health awareness issues to educate customers, discovering and mitigating environmentally based health threats, providing health services, including preventive care and problem intervention, and improving the means and methods for maintaining the health of the beneficiary population by constantly evaluating the performance of the healthcare services system. (JP 4-02 and approved for next edition of JP 1-02.)

Modular. A quality that pertains to the design concept of systems, units, or forces in which specified components are used to create a functional capability that allows for flexibility and diversity in employment. (Source: N/A)

Multinational. Between two or more forces or agencies of two or more nations or coalition partners. See also Alliance; Coalition. (JP 5-0)

Not Seriously Injured. The casualty status of a person whose injury may or may not require hospitalization; medical authority does not classify as very seriously injured, seriously injured, or incapacitating illness or injury; and the person can communicate with the next of kin. See also casualty status. (JP 4-02)

Occupational and Environmental Health Surveillance (OEHS). The regular or repeated collection, analysis, archiving, interpretation, and dissemination of OEHS-related data for monitoring the health of, or potential health hazard impact on, a population and individual personnel, and for intervening in a timely manner to prevent, treat, or control the occurrence of disease or injury when determined necessary. (JP 1-02 and JP 4-02)

Operation Order. A directive issued by a commander to subordinate commanders for the purpose of effecting the coordinated execution of an operation. Also called OPORD. (JP 1-02)

Operational Capability. The ability to effectively employ a system, a weapon, or an item of equipment of approved specific characteristics that is staffed or operated by an adequately trained, equipped, and supported military unit or force. See also Initial Operational Capability. (JP 1-02)

Operational Tempo. The rate, frequency, and intensity of military operations. Also called OPTempo. (JP 1-02)

Organic. Assigned to and forming an essential part of a military organization. Organic parts of a unit are those listed in its table of organization for the Army, Air Force, and Marine Corps, and are assigned to the administrative organizations of the operating forces for the Navy. (JP 1-02)

Patient. A sick, injured, wounded, or other person requiring medical/dental care or treatment. (JP 1-02)

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Patient Movement. The act or process of moving a sick, injured, wounded, or other person to obtain medical and/or dental care or treatment. Functions include medical regulating, patient evacuation, and en-route medical care. (JP 1-02)

Patient Movement Policy. Command decision establishing the maximum number of days that patients may be held within the command for treatment. Patients who, in the opinion of responsible medical officers, cannot be returned to a duty status within the period prescribed are evacuated by the first available means, provided the travel involved will not aggravate their disabilities. (JP 4-02)

Patient Movement Requirements Center. Term used to represent any theater, joint or the Global Patient Movement Requirements Center function. A joint activity that coordinates PM. It is the functional merging of joint medical regulating processes, Services' medical regulating processes, and PM evacuation requirements planning (transport to bed plan). Also called PMRC. (JP 4-02)

Point of Injury. A variable location where a casualty sustains physical damage to the body. (Source: N/A)

Port of Debarkation. The geographic point at which cargo or personnel are discharged. May be a seaport or aerial port of debarkation. For unit requirements, it may or may not coincide with the destination. Also called POD. (JP 1-02)

Port of Embarkation. The geographic point in a routing scheme from which cargo or personnel depart. May be a seaport or aerial port from which personnel and equipment flow to port of debarkation. For unit and non-unit requirements, it may or may not coincide with the origin. Also called POE. (JP 1-02)

Preventive Medicine. The anticipation, communication, prediction, identification, prevention, education, health risk assessment, and control of communicable diseases, illnesses and exposure to endemic, occupational, and environmental threats. These threats include non-battle injuries, combat stress responses, WMD, and other threats to the health and readiness of military personnel. Communicable diseases include arthropod-, vector-, food-, waste-, and waterborne diseases. Preventive medicine measures include field sanitation, medical surveillance, pest and vector control, disease/health risk assessment, environmental and occupational health surveillance, waste (e.g., human, hazardous, and medical) disposal, food safety inspection, and potable water surveillance. Also called PVNTMED. (JP 4-02)

Rehabilitative Care. Therapy that provides evaluations and treatment programs using exercises, massage, or electrical therapeutic treatment to restore, reinforce, or enhance motor performance and restores patients to functional health, allowing for their return to duty or discharge from the service. Also called Restorative Care. (JP 4-02)

Resuscitative Care. Advanced emergency medical treatment required to prevent immediate loss of life or limb and attaining stabilization to ensure that the patient could tolerate evacuation. (JP 4-02)

Risk Communication. The process of adequately and accurately communicating the

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magnitude and nature of potential environmental and occupational health risks to commanders and to service members. (Source: N/A)

Rules of Engagement. Directives issued by competent military authority that delineate the circumstances and limitations under which United States forces will initiate and/or continue combat engagement with other forces encountered. Also called ROE. See also law of war. (JP 1-02)

Scalable. The ability of systems, units, or forces to change in size and increase or decrease capacity or capabilities to meet applicable requirements and continue to function. (Source: N/A)

Seriously Ill or Injured. The casualty status of a person whose illness or injury is classified by medical authority to be of such severity that there is cause for immediate concern, but there is not imminent danger to life. Also called SII. See also Casualty Status. (JP 1-02)

Seriously Wounded. A casualty whose injuries or illness are of such severity that the patient is rendered unable to walk or sit, thereby requiring a litter for movement and evacuation. (JP 1-02)

Shaping. The set of continuous, long-term, integrated, and comprehensive actions among a broad spectrum of US and international government and nongovernmental partners that maintain or enhance stability, prevent or mitigate crises, and enable other operations when crises occur. (Source: N/A)

Slightly Wounded. A casualty whose injuries or illness are relatively minor, permitting the patient to walk and/or sit. (JP 1-02)

Stable. One who, in the best clinical judgment of the responsible physician, can withstand a bed to bed evacuation, and is unlikely to require intervention beyond the scope of standard en-route care capability during the evacuation. (Source: N/A)

Stability Operations. An overarching term encompassing various military missions, tasks, and activities conducted outside the United States in coordination with other instruments of national power to maintain or reestablish a safe and secure environment and provide essential governmental services, emergency infrastructure reconstruction, and humanitarian relief. (JP 3-0) (see SO, SSTRO)

Stabilized Patient. A patient whose airway is secured, hemorrhage is controlled, shock treated, and fractures are immobilized. (JP 1-02)

Stable Patient. A patient for whom no in-flight medical intervention is expected but the potential for medical intervention exists. (JP 1-02)

Standardization. The process by which the Department of Defense achieves the closest practicable cooperation among the Services and Department of Defense agencies for the most efficient use of research, development, and production resources, and agrees to adopt on the broadest possible basis the use of: a) common or compatible operational, administrative, and logistic procedures; b) common or compatible technical procedures

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and criteria; c) common, compatible, or interchangeable supplies, components, weapons, or equipment; and d) common or compatible tactical doctrine with corresponding organizational compatibility. (JP 4-02)

Subject Matter Expert. An individual possessing special knowledge or expertise in a particular area. Also called SME. (Source: N/A)

Supported Commander. 1. The commander having primary responsibility for all aspects of a task assigned by the Joint Strategic Capabilities Plan or other joint operation planning authority. In the context of joint operation planning, this term refers to the commander who prepares operation plans or operation orders in response to requirements of the Chairman of the Joint Chiefs of Staff. 2. In the context of a support command relationship, the commander who receives assistance from another commander's force or capabilities, and who is responsible for ensuring that the supporting commander understands the assistance required. See also support; supporting commander. (JP 3-0)

Supporting Commander. 1. A commander who provides augmentation forces or other support to a supported commander or who develops a supporting plan. This includes the designated combatant commands and Department of Defense agencies as appropriate. 2. In the context of a support command relationship, the commander who aids, protects, complements, or sustains another commander's force, and who is responsible for providing the assistance required by the supported commander. See also support; supported commander. (JP 3-0)

Tailorable. A quality that pertains to the design concept of systems, units, or forces that affords these systems, units or forces the ability to be adapted or customized to fulfill a given purpose, function or requirement. (Source: N/A)

Teams. Official, non-permanent mission tailored groups within a combatant command or JTF that are established for a specific event or action. Teams are typically disestablished upon completion of their intended mission or function. (Source: N/A)

Telemedicine. Rapid access to shared and remote medical expertise by means of telecommunications and information technologies to deliver health services and exchange health information for the purpose of improving patient care. (JP 4-02)

Theater Hospitalization Capability. Essential care and health service support capabilities to either return the patient to duty and/or stabilization to ensure the patient can tolerate evacuation to a definitive care facility outside the theater. It includes modular hospital configurations required to support the theater (emergency medical services, surgical services, primary care, veterinary services, dental services, preventive medicine, and combat and operational stress control, blood banking services, hospitalization, laboratory and pharmacy services, radiology, medical logistics and other medical specialty capabilities as required). (JP 4-02)

Total Asset Visibility. The capability to provide users with timely and accurate information on the location, movement, status, and identity of units, personnel, equipment, materiel, and supplies. It also includes the capability to act on that information to improve overall performance of DoD's logistic practices. Also called

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TAV. See also Automated Identification Technology; In-Transit Visibility; Joint Total Asset Visibility. (JP 4-01.8)

Transformation. The systematic development of efficient programs from high-level specifications. (Source: N/A)

Unity of effort. Coordination and cooperation among all forces toward a commonly recognized objective. (Source: N/A)

Unstable patient. A patient whose physiological status is in fluctuation. Emergency treatment and/or surgical intervention are anticipated during the evacuation. An unstable patient's rapidly changing status and requirements are beyond the standard en-route care capability and requires medical/surgical augmentation. (JP 4-02)

Very seriously ill or injured. The casualty status of a person whose illness or injury is classified by medical authority to be of such severity that life is imminently endangered. Also called VSII. See also casualty status. (JP 1-02)

Wellness. Force health protection program that consolidates and incorporates physical and mental fitness, health promotion, and environmental and occupational health. (JP 1-02)

Wounded. See Seriously Wounded; Slightly Wounded. (JP 1-02)

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